05368

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No.....

1. PLACE OF DEATH: COUNTY ANNE ARUNDEL MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN RURAL - FERNDALE
LENGTH OF STAY (in this place) 36 YRS.
HOSPITAL OR INSTITUTION OR STREET ADDRESS R.F.D. 9-Box 436, Brooklyn P.O

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE MARYLAND COUNTY ANNE ARUNDEL
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN RURAL - FERNDALE
STREET ADDRESS (If rural give location) R.F.D. 9-Box 436, Brooklyn P.O

3. NAME OF DECEASED (Type or Print) (First) MARTIN (Middle) (Last) AUGUSTYNIAK

4. DATE OF DEATH (Month) JUNE (Day) 1, (Year) 1949

5. SEX MALE
6. COLOR OR RACE WHITE
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) WIDOWED.
8. DATE OF BIRTH 10/17/1870
9. AGE last birthday 78 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) POLAND
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME JOSEPH AUGUSTYNIAK
14. MOTHER'S MAIDEN NAME VERONICA ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) N. (If year, give war or dates of service)
16. SOCIAL SECURITY NO. —
17. INFORMANT MR. ALEX AUGUSTYNIAK, RFD 9, 436, Brooklyn P.O.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| 442 Immediate cause | (a) UREMIA AND INANITION | 7 DAYS |
| Antecedent cause(s) | | |
| 131a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (b) GENERALIZED CARDIO-VASCULAR RENAL DISEASE | UNKNOWN |
| | (c) FRACTURED HIP - ONE YEAR AGO. | ONE YEAR. |

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from MAY, 1947, to MAY, 1949, that I last saw the deceased alive on MAY 5, 1949, and that death occurred at 4:00 9. m., from the causes and on the date stated above.

SIGNATURE Henry F. Zangara, M.D. (Degree or title) ADDRESS GLEN BURNIE DATE SIGNED 6-1-49

23. BURIAL, CREMATION REMOVAL (Specify) BURIAL
DATE JUNE 4, 1949
NAME OF CEMETERY OR CREMATORY ST. STANISLAUS
LOCATION (City, town, or county) (State) BALTIMORE, MD.

DATE REC'D BY LOCAL REG. 6/3/49
REGISTRAR'S SIGNATURE A. W. Hedrich
24. FUNERAL DIRECTOR M.F. SADOWSKI & SONS, 1808 EASTERN AVENUE ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

# CERTIFICATE OF DEATH

05369

Reg. Dist. No. 23

**1. PLACE OF DEATH:**

County ANNE ARUNDEL

City or town PASADENA.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? LIFE

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)

State MARYLAND County ANNE ARUNDEL

City or town PASADENA
(If outside city or town limits, write RURAL and give nearest town)

Street No. JOHNSONTOWN
(If rural, give LOCATION)

2.(a) If veteran, name war

**3. (a) FULL NAME** JOSEPH BAKER

**3. (b) Social Security Number**

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| MALE | COLORED | WIDOWED |

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) DECEMBER 1. 1886

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 62 | 6 | 13 | ..... hrs. ..... min. |

9. Birthplace ANNE ARUNDEL Co., MD.,
(Town, county, and state)

10. Usual occupation LABORER

11. Industry or business

FATHER
12. Name HENRY BAKER
13. Birthplace VIRGINIA

MOTHER
14. Maiden name ANNIE E. TURNER.
15. Birthplace MARYLAND

16. Informant MRS. SERENA RICHARDS

Address PASADENA, A. A. Co., MD.

17. BURIAL Date thereof 6-19-49.
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory MAGOTHY

Location A. A. Co., MARYLAND.

18. Funeral director WM. A. JACKSON

Address 916 PENNA., AVE., BALTO. 1.

19. 6/18 1949 L. J. De Alba
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH JUNE 14, 1949, at 1:45 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 6-8 1949 to 6-14 1949

and that I last saw him alive on 6-8-49 19

Immediate cause of death Uremia

Due to Renal Disease

Due to 593

Other conditions 132
(Include pregnancy within 3 months of death)

DURATION

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE G. T. Allen
M. D. or other

Address 10 Carroll Date signed 6-18-49

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

I

Mina Lacomb 605 Bone st

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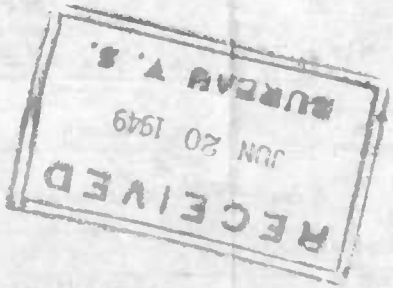
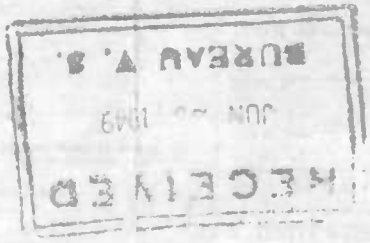
JUN 20 1949
BUREAU V. S.

RECEIVED
JUN 20 1949
BUREAU V. S.





MARYLAND STATE DEPARTMENT OF HEALTH

05370

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No. 26

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Deale, Md. near Annapolis | LENGTH OF STAY (in this place) 50 Yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS Deale, Md. near Annapolis

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Deale, Md. near Annapolis
STREET ADDRESS (If rural, give location) Near- Annapolis, Maryland

3. NAME OF DECEASED (Type or Print): (First) James (Middle) Thomas (Last) Bias

4. DATE OF DEATH: (Month) 6- (Day) 11 (Year) 49

5. SEX: Female

6. COLOR OR RACE: Colored

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: 3/4 /1867

9. AGE last birthday: 82 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: James Bias

14. MOTHER'S MAIDEN NAME: Mc Linda Burley

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If year, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Allen H. Bias- Deale, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Congestive Heart Failure — Interval between onset and death:

434.1 Antecedent cause(s)

93.2 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 6-6, 1949, to 6-11, 1949, that I last saw the deceased alive on 6-10-49, 19....., and that death occurred at 3 P.M., from the causes and on the date stated above.

SIGNATURE A. T. Allen (Degree or title) an D ADDRESS 10 Carroll St DATE SIGNED 6-14-49

23. BURIAL, CREMATION, REMOVAL (Specify): Burial | DATE 6/ 14/ 1949 | NAME OF CEMETERY OR CREMATORY: Union Chapel Cemetery | LOCATION (City, town, or county) (State): Deale, Md. near Annapolis

DATE REC'D BY LOCAL REG. June 14, 1949 | REGISTRAR'S SIGNATURE J. B. Dent

24. FUNERAL DIRECTOR: Mrs. Charles E. Hicks & Son — ADDRESS: 43-45 Northwest Street- Anna polis, Md.

VS. A15

RECEIVED
JUN 17 1949
BUREAU V. S.

Evidence for change of age is on:

MARYLAND STATE DEPARTMENT OF HEALTH Bc 05371

2411 N. Charles Street, Baltimore

FILM No. G 120 JUN 24 1949

# CERTIFICATE OF DEATH

Reg. Dist. No. 28

| | |
|---|---|
| 1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND | 2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Baltimore City |
| CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Crownsville — LENGTH OF STAY (in this place) 4 months | CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS Crownsville State Hospital | STREET ADDRESS (If rural, give location) 790 Mulberry St., |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 3. NAME OF DECEASED (Type or Print) | (First) Milton | (Middle) | (Last) Campbell | 4. DATE OF DEATH | (Month) 6 | (Day) 18 | (Year) 1949 |
| 5. SEX Male | 6. COLOR OR RACE Negro | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married | 8. DATE OF BIRTH 4-6-02 | 9. AGE last birthday ~~37~~ 47 yrs. | If under 1 year Months — Days — | If under 24 hrs. Hours — Min. — | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter | 10b. KIND OF BUSINESS OR INDUSTRY None | 11. BIRTHPLACE (State or foreign country) Maryland | 12. CITIZEN OF WHAT COUNTRY? U. S. | | | | |
| 13. FATHER'S NAME John Campbell | 14. MOTHER'S MAIDEN NAME Carter | | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) — — — (If year, give war or dates of service) — — — | 16. SOCIAL SECURITY NO. — — — — — — | 17. INFORMANT Hospital Records | | | | | |

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

002

Immediate cause (a) Pulmonary Hemorrhage

Antecedent cause(s)

13b

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Pulmonary tuberculosis — Known since admission 2/9/49

(c) Schizophrenia- Paranoid Type

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

| | | |
|---|---|---|
| 19a. DATE OF OPERATION — — — — — — | 19b. MAJOR FINDINGS OF OPERATION — — — — — — — — — | 20. AUTOPSY? Yes ☐ No ☐ |
| 21. ACCIDENT SUICIDE HOMICIDE (Specify) — — — — — | PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — — — — — — | (CITY OR TOWN) — — — — (COUNTY) — — (STATE) — — — |
| TIME OF INJURY (Month) (Day) (Year) (Hour) — — — — — — m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR? — — — — |

22. I hereby certify that I attended the deceased from 2-9-, 1949, to June 18, 1949, that I last saw the deceased alive on June 18, 1949, and that death occurred at 5:50 a. m., from the causes and on the date stated above.

| SIGNATURE | (Degree or title) | ADDRESS | DATE SIGNED |
|---|---|---|---|
| Jacob Rosenstein | M.D. | Crownsville, Maryland | June 18, '49 |

| | | | |
|---|---|---|---|
| 23. BURIAL, CREMATION REMOVAL (Specify) | DATE June 22 | NAME OF CEMETERY OR CREMATORY Mt Auburn | LOCATION (City, town, or county) Balt. City (State) md. |
| DATE REC'D BY LOCAL REG. 6/18-49 | REGISTRAR'S SIGNATURE E. F. Joyce Local Register | 24. FUNERAL DIRECTOR Mr Samuel T. Hemsley | ADDRESS 578 W. Biddle St. |

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
JUN 21 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

05372

# CERTIFICATE OF DEATH

Reg. Dist. No. 28

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH
COUNTY: Anne Arundel — STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Crownsville
LENGTH OF STAY (in this place): 2½ Months
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Crownsville State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland — COUNTY: Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Carr's Beach, Annapolis
STREET ADDRESS (If rural, give location):

| 3. NAME OF DECEASED (Type or Print) (First) | (Middle) | (Last) | 4. DATE OF DEATH (Month) | (Day) | (Year) |
|---|---|---|---|---|---|
| Frederick | Louis | Carr | June | 3 | 1949 |

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE last birthday | If under 1 year: Months | Days | If under 24 hrs.: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Male | Colored | Divorced | October 1879 | 69 yrs. | | | | |

| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Laborer | | Maryland | U.S. |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Fred Carr | Mary Wells |

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | (If year, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT |
|---|---|---|---|
| No | | | Hospital records |

18. MEDICAL CERTIFICATION

| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| 025 Immediate cause | (a) General Paresis | Over five years |
| Antecedent cause(s) | | |
| 30b Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (b) | |
| | (c) | |
| II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. | | |

| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | Yes ☐ No ☒ |

| 21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE) |
|---|---|---|---|---|
| | | | | |

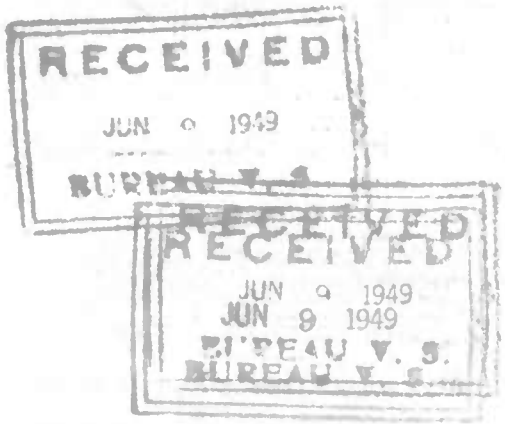
| TIME OF INJURY (Month) | (Day) | (Year) | (Hour) | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR? |
|---|---|---|---|---|---|
| | | | m. | | |

22. I hereby certify that I attended the deceased from 3/17, 1949, to 6/3/49, 19....., that I last saw the deceased alive on 6/3/49, 19....., and that death occurred at 10:40 P. M., from the causes and on the date stated above.

| SIGNATURE | (Degree or title) | ADDRESS | DATE SIGNED |
|---|---|---|---|
| Arnold H. Eichert, M.D. | | Crownsville, Maryland | 6/4/49 |

| 23. BURIAL, CREMATION REMOVAL (Specify) | DATE | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) | (State) |
|---|---|---|---|---|
| Burial | June 7 1949 | St. Ann | Annapolis | Md |

| DATE REC'D BY LOCAL REG. | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| June 7, 1949 | C. F. Joyce Local Reg. | J. B. Johnson | Annapolis |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JUN 9 1949
BUREAU V. S.
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JUN 9 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

# CERTIFICATE OF DEATH
## FOR MEDICAL EXAMINERS

05373

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Arnold
LENGTH OF STAY (In this place) 1 yr 6 mos
HOSPITAL OR INSTITUTION OR STREET ADDRESS Manhattan Beach

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Balto.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore - 29
STREET ADDRESS (If rural, give location) 4301 Wilkins Ave.

| 3. NAME OF DECEASED (Type or Print) | (First) | (Middle) | (Last) | 4. DATE OF DEATH (Month) | (Day) | (Year) |
|---|---|---|---|---|---|---|
| | Edward | J. | Carroll | June | 26 | 1949 |

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE last birthday | If under 1 year: Months | Days | If under 24 hrs.: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| male | White | Single | 5/1/1928 | 21 yrs. | | | | |

| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Ferrel Duct Insp | Factory | Baltimore Md | U.S.A. |

13. FATHER'S NAME Ernest Carroll
14. MOTHER'S MAIDEN NAME Marie E. Cavanaugh

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT |
|---|---|---|
| no | 215-28-6234 | Donald E. Baus |

18. MEDICAL CERTIFICATION

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | |
| Immediate cause | (a) Drowning | Sudden |
| Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (b) Accidental | |
| | (c) | |
| II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. | | |

929.4
183

| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | Yes ☐ No ☐ |

| 21. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH. | PLACE (Home, farm, factory, street, office building, etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE) |
|---|---|---|---|---|
| | Manhattan Beach | Arnold P.O | A.A. | Md |

| TIME (Month) (Day) (Year) (Hour) OF INJURY | INJURY OCCURRED While at work ☐ Not while at work ☑ | HOW DID INJURY OCCUR? |
|---|---|---|
| June 26. 1949 6 p.m. | | Was in Swimming |

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐.*

| SIGNATURE | (Degree or title) | ADDRESS | DATE SIGNED |
|---|---|---|---|
| John M. Claffy | M.D., Deputy Medical Examiner | Annapolis Md | 6-26-49 |

| 23. BURIAL, CREMATION, REMOVAL (Specify) | DATE THEREOF | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 6/30/49 | Loudon Park Cem. | 3861 Frederick Ave |

| DATE REC'D BY LOCAL REG. | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| 6/27/49 | A.W. Hedrick | John J. Cowan & Son | 9 Gallison St. |

VS-A15A

05374

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No.....

1. PLACE OF DEATH — COUNTY: Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN — LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Riverview Nursing Home Riva. Md.

2. USUAL RESIDENCE (HOME) OF DECEASED — STATE: Maryland — COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Lombrills
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print): (First) George (Middle) Benjamin (Last) Clark
4. DATE OF DEATH: (Month) June (Day) 25 (Year) 1949
5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Divorced
8. DATE OF BIRTH: Dec 16 1874
9. AGE last birthday: 74 yrs. — If under 1 year: Months, Days — If under 24 hrs.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: John T. Clark
14. MOTHER'S MAIDEN NAME: Margaret Gardner
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If year, give war or dates of service)
16. SOCIAL SECURITY NO.: none
17. INFORMANT: Gordon C. Clark, Linthicum Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Arteriosclerotic cardiovascular disease — 10 yrs (?)

422.1

Antecedent cause(s)

93d

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c) malnutrition — (?)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURRED While at Work ☐ Not While At work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 6/20/, 1949, to 6/25, 1949, that I last saw the deceased alive on 6/25, 1949, and that death occurred at 10 15 P m., from the causes and on the date stated above.

SIGNATURE: S. Bossuch (Degree or title) M.D. — ADDRESS: Annapolis Md — DATE SIGNED: 6/26/49

23. BURIAL, CREMATION REMOVAL (Specify): Burial — DATE: 6/28/49 — NAME OF CEMETERY OR CREMATORY: Friendship — LOCATION (City, town, or county): Anne Arundel Co (State) Md

DATE REC'D BY LOCAL REG.: 6/27/49 — REGISTRAR'S SIGNATURE: C. W. Hedrick — 24. FUNERAL DIRECTOR: Wilhoin Co. Inc — ADDRESS: 1217 St Paul St

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

# CERTIFICATE OF DEATH

## FOR MEDICAL EXAMINERS

05375

Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
LENGTH OF STAY (In this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Annapolis Emergency Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Montgomery
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Bethesda
STREET ADDRESS (If rural, give location) 4601 West Virginia Avenue

3. NAME OF DECEASED (Type or Print) (First) Paul (Middle) Randolph (Last) Clatterbuck
4. DATE OF DEATH (Month) June (Day) 14 (Year) 1949
5. SEX Male
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single
8. DATE OF BIRTH March 22, 1929
9. AGE last birthday 20 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retail salesman
10b. KIND OF BUSINESS OR INDUSTRY Baking
11. BIRTHPLACE (State or foreign country) Washington, D. C.
12. CITIZEN OF WHAT COUNTRY? U. S.
13. FATHER'S NAME Randolph Browning Clatterbuck
14. MOTHER'S MAIDEN NAME Clara Juliette Post
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Father

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

902.4 Immediate cause (a) Transection of spinal cord — 3 days

186a Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Fracture of cervical vertebrae — 3 days

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. None

19a. DATE OF OPERATION None
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☑

21. EXTERNAL CAUSE WAS PRIMARY ☑ OR CONTRIBUTING ☐ CAUSE OF DEATH.
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Public Beach (CITY OR TOWN) Mayo (COUNTY) A. A. (STATE) Md.
TIME OF INJURY (Month) (Day) (Year) (Hour) 6 - 11 - 49 1:30 p.m.
INJURY OCCURRED While at work ☐ Not while at work ☑
HOW DID INJURY OCCUR? Diving into shallow water

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE (Degree or title) E. Peyton Ritchings, M.D. ADDRESS Acting P.M.E. Annapolis, Md. DATE SIGNED 6-14-49

23. BURIAL, CREMATION REMOVAL (Specify) Removal
DATE THEREOF 6-16-49
NAME OF CEMETERY OR CREMATORY Rock Creek
LOCATION (City, town, or county) Washington (State) D.C.
DATE REC'D BY LOCAL REG. June 14, 1949
REGISTRAR'S SIGNATURE [signature]
24. FUNERAL DIRECTOR Robert A. Pumphrey CPA ADDRESS 7557 Wis. Ave. Bethesda, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

RECEIVED
JUN 16 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

05376

# CERTIFICATE OF DEATH

Reg. Dist. No. 20

MARGIN RESERVED FOR BINDING — PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY Anne Arundel | MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Edgewater | LENGTH OF STAY (in this place) 1 YR.
HOSPITAL OR INSTITUTION OR STREET ADDRESS A.A. County Home

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland | COUNTY Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN
STREET ADDRESS (If rural, give location)

| 3. NAME OF DECEASED (Type or Print) (First) | (Middle) | (Last) | 4. DATE OF DEATH (Month) | (Day) | (Year) |
|---|---|---|---|---|---|
| William | | Colbert. | June | 7 | 1949 |

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE last birthday | If under 1 year: Months | Days | If under 24 hrs.: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Male | Colored | Unknown | 6-13-1868 | 81 yrs. | | | | |

| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| ✓ | ✓ | Unknown | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Unknown | Unknown |

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT |
|---|---|---|
| Unknown | ✓ | Record of G.A. Co Home |

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| Immediate cause | (a) Arteriosclerotic Heart disease | 2 yrs. |
| Antecedent cause(s) | (b) C Decompensation. | |
| Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (c) | |

420.0
932

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | Yes ☐ No ☒ |

| 21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE) |
|---|---|---|---|---|
| | | | | |

| TIME OF INJURY (Month) | (Day) | (Year) | (Hour) | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR? |
|---|---|---|---|---|---|
| | | | m. | | |

22. I hereby certify that I attended the deceased from 6/11, 1948, to 6/7, 1949, that I last saw the deceased alive on 6/3, 1949, and that death occurred at 11:30 A m., from the causes and on the date stated above.

| SIGNATURE (Degree or title) | ADDRESS | DATE SIGNED |
|---|---|---|
| Maurice J. Kavanaugh, M.D. | Annapolis, Md | 6/7/49 |

| 23. BURIAL, ~~CREMATION~~ REMOVAL (Specify) | DATE | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) | (State) |
|---|---|---|---|---|
| | June 9. 1949 | G.A. Co Home | Edgewater | Md |

| DATE REC'D BY LOCAL REG. | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| 6/7/49 | Edward Colleran | D.A. Hardesty | Galesville Md. |

VS. A15

RECEIVED
JUN 13 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

05377

# CERTIFICATE OF DEATH

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH: COUNTY Anne Arundel; MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis; LENGTH OF STAY (in this place) Life; HOSPITAL OR INSTITUTION OR STREET ADDRESS 32 Taylor Street

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Anne Arundel; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis; STREET ADDRESS (If rural give location) Monument Street

3. NAME OF DECEASED (Type or Print): (First) Harry (Middle) Cecil (Last) Cooper

4. DATE OF DEATH: (Month) 6/ (Day) 20 (Year) 1949

5. SEX: Male

6. COLOR OR RACE: Colored

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): Widowed

8. DATE OF BIRTH: 6/23/1885

9. AGE last birthday: 63 yrs. If under 1 year: Months ____ Days ____ If under 24 hrs.: Hours ____ Min. ____

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Barber

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (State or foreign country): Annapolis, Maryland

12. CITIZEN OF WHAT COUNTRY? ____

13. FATHER'S NAME: Greenbury Cooper

14. MOTHER'S MAIDEN NAME: Nannie Murdock

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown): No (If year, give war or dates of service) ____

16. SOCIAL SECURITY No.: None

17. INFORMANT: Victoria Davis

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Carcinoma of Stomach with spread to retro peritoneal glands

151 Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last 46b (b) ____

(c) ____

INTERVAL BETWEEN ONSET AND DEATH

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office hldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 6-16 1949, to 6-20 1949, that I last saw the deceased alive on 6-20 1949, and that death occurred at 11 P m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

G. T. Allen MD 10 Carroll St. 6-22-49

23. BURIAL, CREMATION REMOVAL (Specify) Burial | DATE 6/25/1949 | NAME OF CEMETERY OR CREMATORY Brewer Hill Cemetery | LOCATION (City, town, or county) (State) West St. Extended* Annapolis

DATE REC'D BY LOCAL REG. June 23, 1949 | REGISTRAR'S SIGNATURE [signature] | 24. FUNERAL DIRECTOR ADDRESS Mrs. Charles E. Hicks & Son 43-45 Northwest Street Annapolis,

RECEIVED
JUN 24 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

05378

# CERTIFICATE OF DEATH

Reg. Dist. No. 20

1. PLACE OF DEATH: COUNTY a a MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Bristol
LENGTH OF STAY (in this place) 3 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY a a
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Bristol
STREET ADDRESS (If rural give location)

3. NAME OF DECEASED (Type or Print) (First) Charles (Middle) W (Last) Cox
4. DATE OF DEATH (Month) June (Day) 30 (Year) 1949
5. SEX m
6. COLOR OR RACE w
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) widow
8. DATE OF BIRTH April 4-1889
9. AGE last birthday 60 yrs. If under 1 year Months 2 Days 16 If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lumberman
10b. KIND OF BUSINESS OR INDUSTRY Saw mill
11. BIRTHPLACE (State or foreign country) Lerona West Va
12. CITIZEN OF WHAT COUNTRY? U S A
13. FATHER'S NAME Mathew Cox
14. MOTHER'S MAIDEN NAME Virginia Farley
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 213-28-6642
17. INFORMANT Clacy C Cox

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | | Interval Between Onset and Death |
|---|---|---|---|
| 420.1 | Immediate cause | (a) Coronary Thrombosis | 1 hr |
| 93d | Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (b) Hypertensive CV Disease | 10 yrs |
| | | (c) | |

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Prev. coronary thrombosis + cerebral vasc. accident

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1 Apr, 1949, to 30 June 1949, that I last saw the deceased alive on 29 June, 1949, and that death occurred at 8.50 A.m., from the causes and on the date stated above.

SIGNATURE Robert B Sasser (Degree or title) MD ADDRESS Upper Marlboro Md DATE SIGNED 6-30-49

23. BURIAL, CREMATION REMOVAL (Specify) B Removal
DATE THEREOF July 1/49
NAME OF CEMETERY OR ~~CREMATORY~~ Lerona.
LOCATION (City, town, or county) Lerona (State) West Va

DATE REC'D BY LOCAL REG. 6/30/49
REGISTRAR'S SIGNATURE W. R. Clayton Dep. Chief Reg
24. FUNERAL DIRECTOR B. L. Happings ADDRESS Annapolis Md

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
JUL 6 1949
BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

05379

Reg. Dist. No. 26

**1. PLACE OF DEATH:**

County: Anne Arundel

City or town: Rural - Drury

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 mo.

Hospital, institution, or street address where death occurred: Route # 4

How long in hospital or institution?

**2. USUAL RESIDENCE (HOME) OF DECEASED:**

(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Rural - Drury

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Route # 4

(If rural, give LOCATION)

2.(a) If veteran, name war

**3. (a) FULL NAME:** Walter Oscar Cox

**3. (b) Social Security Number:**

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| M | W | S |

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): May 4, 1949

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| | 1 | 5 | ..... hrs. ..... min. |

9. Birthplace: Drury A A Md (Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER — 12. Name: Walter Oscar Cox

13. Birthplace: Floyd, Va.

MOTHER — 14. Maiden name: Margie Lester

15. Birthplace: Floyd, Va.

16. Informant: Walter O Cox

Address: Drury, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 6/10/49 (month) (day) (year)

Cemetery or crematory: Mt Zion

Location: Lothian, Md.

18. Funeral director: T A Hardesty & Son

Address: Edgewood, Md.

19. June 10 1949 (Date rec'd by registrar) D. B. Dent Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: June 9 1949 at 6 10 A.M.

21. I CERTIFY that death occurred on the date above stated; ~~that I attended deceased from~~ ..... 19.... to ..... 19.....

~~and that I last saw him~~ ..... alive on ..... 19.....

| Immediate cause of death | DURATION |
|---|---|
| Asphyxia | |
| Due to: Suffocation | |
| Due to: 994.0 | |
| Other conditions: 182 | |

(Include pregnancy within 3 months of death)

Major findings of operation ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident Date of: 6/9/49

Where did injury occur? Drury (City or town) A.A. (County) Md. (State)

Injured at home, farm, industry, public place (where?): Home

Means of injury: Suffocation Injured at work?

23. SIGNATURE: E. Peyton Ritchie, Jr., M.D. M. D. or other

Address: Annapolis, Md. Date signed: 6/9/49

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-48

RECEIVED
JUN 11 1949
BUREAU V. S.

MOTHER

MARY THOMPSON

1903 - 1949

Mr Randall

Wm J.

6737

05380

Evidence for change in birth date shown on:
FILM No. G 120 JUN 28 1949

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 21

**1. PLACE OF DEATH:**
County Anne Arundel
City or town Severna Park
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 13 days.
Hospital, institution, or street address where death occurred: Cedar Crest Nursing Home
How long in hospital or institution? 13 days.

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State Md. County Ann Arundel
City or town P.O. Glen Burnie
(If outside city or town limits, write RURAL and give nearest town)
Street No. Solley Road
(If rural, give LOCATION)
2.(a) If veteran, name war NO

**3. (a) FULL NAME** Selma Virginia Edwards

**3. (b) Social Security Number**

4. Sex: F.
5. Color or race: Colored.
6.(a) Single, married, widowed, or divorced: Divorced.
6.(b) Name of husband ~~or wife~~: Garfield Butler
6.(c) If alive, give age 35 years
7. Birth date of deceased (mo., day, yr.) April 30 - ~~1930~~ 1920

**8. AGE:** Years 39 | Months 1 | Days 17 | If less than one day ..... hrs. ..... min.

8. Birthplace Glen Burnie, Md.
(Town, county, and state)
10. Usual occupation Housewife
11. Industry or business
FATHER
12. Name James Garrison Edwards
13. Birthplace Maryland
MOTHER
14. Maiden name Esther Ann Richards
15. Birthplace Maryland
18. Informant Mrs. Laura Edwards
Address Glen Burnie, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 6-21-49 (month) (day) (year)
Cemetery or crematory Halls Men Church Ct
Location A. A. Co., Md
18. Funeral director Isaiah L. Brown & Son
Address 108 W Montgomery St
19. 6/20 1949 (Date rec'd by registrar) H. W. Hedrick DM Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH June 17 1949, at 6:45 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 6 1949, to June 17 1949 and that I last saw her alive on June 17 1949
Immediate cause of death: Cerebral Hemorrhage — DURATION 14 hrs.
Due to Unknown.
Due to 331
Other conditions 83a
(Include pregnancy within 3 months of death)
Major findings of operations —
Date of op.
Autopsy results —
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of
Where did injury occur? — (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury — Injured at work?

23. SIGNATURE Gustave H. Pauber MD M. D. or other
Address Glen Burnie, Md. Date signed 6/18/49

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-4 M

MARYLAND STATE DEPARTMENT OF HEALTH

# CERTIFICATE OF DEATH

## FOR MEDICAL EXAMINERS

05381

Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis R.F.D #4
LENGTH OF STAY (in this place) 7 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS Severn Grove

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY A.A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis R.F.D #4
STREET ADDRESS (If rural, give location) Severn Grove

3. NAME OF DECEASED (Type or Print) (First) Caroline (Middle) (Last) Ferris
4. DATE OF DEATH (Month) June (Day) 28, (Year) 1949
5. SEX female
6. COLOR OR RACE white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) widowed
8. DATE OF BIRTH unknown ~~[illegible]~~ 1856
9. AGE last birthday 93 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homewife
10b. KIND OF BUSINESS OR INDUSTRY House
11. BIRTHPLACE (State or foreign country) Sweeden
12. CITIZEN OF WHAT COUNTRY? Sweeden
13. FATHER'S NAME unknown
14. MOTHER'S MAIDEN NAME unknown
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Mrs. Mabel Magruder

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|---|
| 442 | Immediate cause | (a) Acute Cardiac Failure | Sudden |
| 1310 | Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (b) Chronic Cardio-renal disease | unknown |
| | | (c) General arterio-sclerosis | unknown |

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Senility

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at work ☐ Not while at work ☐
HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE John M. Claffy (Degree or title) M.D., Deputy Medical Examiner, ADDRESS Annapolis, Md DATE SIGNED 6-28-49

23. BURIAL, ~~CREMATION~~ REMOVAL (Specify) DATE THEREOF 6-30-49 NAME OF CEMETERY OR CREMATORY Arlington National LOCATION (City, town, or county) Arlington (State) Va

DATE REC'D BY LOCAL REG. June 29, 1949 REGISTRAR'S SIGNATURE [illegible] 24. FUNERAL DIRECTOR John M. Taylor Son ADDRESS Annapolis Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

RECEIVED
JUN 30 1949
BUREAU V. S.

1016 S. East Ave

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

05382

Reg. Dist. No. 25

**1. PLACE OF DEATH:**

County: Anne Arundel

City or town: Pasadena (if outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

**2. USUAL RESIDENCE (HOME) OF DECEASED:** (For newborn infants give residence of mother)

State: Md. County: A.A.

City or town: Pasadena (if outside city or town limits, write RURAL and give nearest town)

Street No.: Mt. Bar Road (if rural, give LOCATION)

2.(a) If veteran, name war

**3.(a) FULL NAME:** John W. Filliaux

**3.(b) Social Security Number**

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| M | W | M |

6.(b) Name of husband or wife: Sophie D. Deems

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): 8/31/1867

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 81 | 9 | 7 | ..... hrs. ..... min. |

9. Birthplace: Md. (Town, county, and state)

10. Usual occupation: Brick mason

11. Industry or business

FATHER: 12. Name: Christopher Filliaux

13. Birthplace

MOTHER: 14. Maiden name: Mary Steelburg

15. Birthplace

16. Informant: Family

Address: 258 S. Bouldin St.

17. B (Burial, cremation, or removal, Which?) Date thereof: 6/11/49 (month) (day) (year)

Cemetery or crematory: Mt. Carmel

Location: O'Donnell Street

18. Funeral director: James L. McCuse

Address: 130 East Fort Avenue

19. June 11 1949 (Date rec'd by registrar) Ida M. Whitson, Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH: 6/8/ 1949 at 10:08 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 7/14/47 19.. to 6/7/49 19..

and that I last saw h.. alive on 5/30/49 19..

Immediate cause of death: Hypertensive Cardio Vascular Disease

Due to: Cr. Myo. condition

Due to: 443 93d

Other conditions: Hypertrophic Arthritis, & Senility (include pregnancy within 3 months of death)

DURATION: 2 yr.

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ..... Injured at work?

23. SIGNATURE: Mitchell F. Kurkowski, M. D. or other

Address: 1016 S. East Ave. Date signed: 6/10/49

VS A15 MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JUN 13 1949
BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

05383

# CERTIFICATE OF DEATH

Reg. Dist. No. 2

**1. PLACE OF DEATH:**

County Anne Arundel

City or town Severna Park

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 days

Hospital, institution, or street address where death occurred: Cedar Crest Nursing Home.

How long in hospital or institution? 4 days

**2. USUAL RESIDENCE (HOME) OF DECEASED:**

(For newborn infants give residence of mother)

State Maryland County

City or town Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 611 - W. West St.

(If rural, give LOCATION)

2.(a) If veteran, name war ✓

**3. (a) FULL NAME** Robert Gable

**3. (b) Social Security Number** None.

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| M. | W. | Widowed. |

6.(b) Name of husband or wife ?

Dead. 6.(c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) ? 1870 (APPROX.)

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 79 | ? | ? | hrs. min. |

9. Birthplace Maryland. (Town, county, and state)

10. Usual occupation Unknown

11. Industry or business

FATHER

12. Name William Gable

13. Birthplace ?

MOTHER

14. Maiden name ?

15. Birthplace

16. Informant Cedar Crest N. Home,

Address Severna Park. Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 13, 1949 (month) (day) (year)

Cemetery or crematory Mount Olivet

Location Frederick Ave. Balto. Md.

18. Funeral director J. T. Ambrose

Address 1328 Sulphur Spring Rd.

19. 6/10 1949 H. W. Hedrick Registrar

(Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH June 9 1949 at 4.30 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 5 1949 to 6/8/49 19

and that I last saw him alive on 6/8/49 19

| Immediate cause of death | DURATION |
|---|---|
| Acute myocarditis | Unknown |
| Due to Mixed-cells tumor of Parotide gland | Unknown |
| Due to | |
| Other conditions General arteriosclerosis | ? |

142.1 (Include pregnancy within 3 months of death)

Major findings of operations —

55e Date of op.

Autopsy results —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide No Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Gustave H. Rauber M.D. M. D. or other

Address Glen Burnie Date signed 6/9/49

VS A15 9-...5M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

I

M

MARGIN RESERVED FOR BINDING

1747

79

1770

# MARYLAND STATE DEPARTMENT OF HEALTH

05384

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

**1. PLACE OF DEATH**
COUNTY: Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Severn
LENGTH OF STAY (in this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS:

**2. USUAL RESIDENCE (HOME) OF DECEASED**
STATE: Md. — COUNTY: Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Severn
STREET ADDRESS (If rural, give location):

| 3. NAME OF DECEASED (Type or Print) (First) | (Middle) | (Last) | 4. DATE OF DEATH (Month) (Day) (Year) |
|---|---|---|---|
| LOUIS | WALTER | HEATHCOTE | June 26, 1949 |

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE last birthday | If under 1 year: Months / Days | If under 24 hrs.: Hours / Mins. |
|---|---|---|---|---|---|---|
| male | white | married | Oct. 15, 1889 | 59 yrs. | | |

| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| retired | | Baltimore, Md. | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| // Louis Carlos Heathcote | // Emma Jane Cramer |

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT |
|---|---|---|
| no | no | Mrs. Esther L. Heathcote Severn, Md. |

**18. MEDICAL CERTIFICATION**

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

**Immediate cause** (a) Paralio-Vascular Disease — 1 yr.

422.1

**Antecedent cause(s)** Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

124 b

(b)

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Cirrhosis of Liver — 5 yrs.

| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | Yes ☐ No ☐ |

| 21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE) |
|---|---|---|---|---|
| | | | | |

| TIME OF INJURY (Month) (Day) (Year) (Hour) | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR? |
|---|---|---|
| m. | | |

22. I hereby certify that I attended the deceased from ..., 1936, to June 26, 1949, that I last saw the deceased alive on June 26, 1949 and that death occurred at 8 P. M. m., from the causes and on the date stated above.

| SIGNATURE | (Degree or title) | ADDRESS | DATE SIGNED |
|---|---|---|---|
| Chas. A. Ball Jr MD | | Linthicum Md. | 6/30/49 |

| 23. BURIAL, CREMATION, REMOVAL (Specify) | DATE THEREOF | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 6/29/49 | Friendship Cem. | A. A. Co. Md. |

| DATE RECD BY LOCAL REG. | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| 6/29/49 | A. W. Hedrick | WM. J. TICKNER & SONS | Balto., Md. |

25

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

05385

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

**1. PLACE OF DEATH:**
County: Anne Arundel
City or town: Bay Side Beach
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 Yrs.
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State: Md. County: Anne Arundel
City or town: Bay Side Beach
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Harbor Rd. near Dryer Rd.
(If rural, give LOCATION)
2.(a) If veteran, name war:

**3.(a) FULL NAME:** Ella V. Heckner

**3.(b) Social Security Number:**

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Female | White | Married |

6.(b) Name of husband or wife: John Heckner
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): February 28, 1883

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 66 | 3 | 7 | hrs. min. |

9. Birthplace: Carroll Co., Md.
(Town, county, and state)
10. Usual occupation: House-wife
11. Industry or business

FATHER
12. Name: Edward Ireland
13. Birthplace: Carroll Co., Md.

MOTHER
14. Maiden name: Sarah D. Moran
15. Birthplace: Md.

16. Informant: Mr. John Heckner
Address: Bay Side Beach

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 6-7-49 (month) (day) (year)
Cemetery or crematory: xxx Loudon Park
Location: Baltimore, Md.

18. Funeral director: G. Howard Strong
Address: 3207 W. North Ave.,

19. 6/7 1949 (Date rec'd by registrar) A.W. Nedich Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: June 4 1949, at 3:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1, 1949, to June 4, 1949, and that I last saw h.. alive on June 4, 1949.

| | DURATION |
|---|---|
| Immediate cause of death: Heart Failure | |
| Due to: Arteriosclerotic Heart Disease | 2 years |
| Due to: Hypertension 420.0 | 2 years |
| Other conditions: Diabetes Mellitus 61 | 2 years |

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: J. Brady Smith M.D. (M. D. or other)
Address: Riviera Beach Md. Date signed: 6/4/49

MARYLAND STATE DEPARTMENT OF HEALTH

# CERTIFICATE OF DEATH
## FOR MEDICAL EXAMINERS

105386

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY Anne Arundel; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN St. Margaret's; MARYLAND LENGTH OF STAY (In this place) 14 years; HOSPITAL OR INSTITUTION OR STREET ADDRESS old St. Margaret's

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Anne Arundel; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN St. Margarets, Annapolis Md; STREET ADDRESS (If rural, give location) old St. Margaret's Road

3. NAME OF DECEASED (Type or Print): (First) Oscar (Middle) Karl (Last) Hirschfeld

4. DATE OF DEATH: (Month) June (Day) 19 (Year) 1949

5. SEX: male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): single

8. DATE OF BIRTH: Oct. 28, 1877

9. AGE last birthday: 71 yrs. If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Boatswain U.S.N.

10b. KIND OF BUSINESS OR INDUSTRY: U.S. Navy

11. BIRTHPLACE (State or foreign country): Germany

12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME: Oscar Hirschfeld

14. MOTHER'S MAIDEN NAME: unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) U.S. Navy

16. SOCIAL SECURITY NO.

17. INFORMANT: Mrs. Elizabeth Hirschfeld, Widow

18. MEDICAL CERTIFICATION

| 1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| Immediate cause | (a) Acute Dilatation of Heart | Sudden |
| Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (b) Chronic myocarditis | unknown |
| | (c) General arteriosclerosis | unknown |
| 11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. | | |

422.1
93d

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

John M. Caffey M.D. Deputy Medical Examiner Annapolis Md 6-19-49

23. BURIAL, CREMATION, REMOVAL (Specify) Burial; DATE THEREOF 6-21-49; NAME OF CEMETERY OR CREMATORY U.S. National Cemetery; LOCATION (City, town, or county) Annapolis (State) Md.

DATE REC'D BY LOCAL REG. June 20, 1949; REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR John N. Saylor & Son ADDRESS Annapolis, Md

VS. A15A

RECEIVED
JUN 21 1949
BUREAU T. S.

05387

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No.....

M

I

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY A. A. Co MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Cedar Crest Nursing Home

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md COUNTY A. A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Orchard Beach Cedar Crest Nursing Home
STREET ADDRESS (If rural, give location) Rural

3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) Mary E. Hopp
4. DATE OF DEATH (Month) (Day) (Year) 6/2/49 19

5. SEX Female
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed
8. DATE OF BIRTH May 21-1868
9. AGE last birthday 81 yrs. If under 1 year Months. Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None
10b. KIND OF BUSINESS OR INDUSTRY —
11. BIRTHPLACE (State or foreign country) Balto Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Charles Weiners
14. MOTHER'S MAIDEN NAME Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)
16. SOCIAL SECURITY No.
17. INFORMANT Joseph C. Hopp Orchard Beach Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Uremia

422.1 Antecedent cause(s)

93d Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Arteriosclerotic Cardio Vascular Disease

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death Arteriosclerotic gangrene-hand 19 feet

19a. DATE OF OPERATION —
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 5/31, 1949, to 6/2, 1949, that I last saw the deceased alive on 6/2, 1949, and that death occurred at 8:15 P m., from the causes and on the date stated above.

SIGNATURE (Degree or title) Bobby L. Jones, M.D. ADDRESS 601 Binstead Road Hazelwood DATE SIGNED 6/2/49

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE 6/6/49
NAME OF CEMETERY OR CREMATORY Holy Redeemer
LOCATION (City, town, or county) (State) Balto Md.

DATE REC'D BY LOCAL REG. June 4th-1949
REGISTRAR'S SIGNATURE R. W. Hedrick
24. FUNERAL DIRECTOR Wm Cook Inc ADDRESS 1217 St. Paul St

MARYLAND STATE DEPARTMENT OF HEALTH Pse 05388

# CERTIFICATE OF DEATH
## FOR MEDICAL EXAMINERS

Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Pasadena PO
LENGTH OF STAY (in this place) ?
HOSPITAL OR INSTITUTION OR STREET ADDRESS Beechgrove Park

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore -16
STREET ADDRESS (If rural, give location) 2822 Raynor Ave.

3. NAME OF DECEASED (Type or Print) (First) Lloyd (Middle) LeRoy (Last) Howard
4. DATE OF DEATH (Month) June (Day) 26 (Year) 1949
5. SEX male
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) married
8. DATE OF BIRTH 4/17/1913
9. AGE last birthday 36 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10b. KIND OF BUSINESS OR INDUSTRY metals
11. BIRTHPLACE (State or foreign country) Balto. Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Walter L. Howard
14. MOTHER'S MAIDEN NAME Pearl M. Simms
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No. (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 216-01-9019
17. INFORMANT Mrs. Florence V. Howard 2822 Raynor Ave.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

850,8 Immediate cause (a) Drowning

183 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Accidental

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☑

21. EXTERNAL CAUSE WAS PRIMARY ☑ OR CONTRIBUTING ☐ CAUSE OF DEATH.
PLACE OF INJURY (Home, farm, factory, street, office, bldg., etc.) Chesapeake Bay near (CITY OR TOWN) Beechgrove Park (COUNTY) Pasadena, A.A. (STATE) Maryland
TIME OF INJURY (Month) June (Day) 26 (Year) 1949 (Hour) 7 00 pm.
INJURY OCCURRED While at work ☐ Not while at work ☑
HOW DID INJURY OCCUR? Was swept overboard from boat into Bay

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE John M. Claffy M.D. (Degree or title) Deputy Medical Examiner ADDRESS Annapolis, Maryland DATE SIGNED 6-28-49

23. BURIAL, CREMATION, REMOVAL (Specify) Burial
DATE THEREOF 6/30/49
NAME OF CEMETERY OR CREMATORY Poplar Grove Cem.
LOCATION (City, town, or county) Balto. Co. (State) Md.
DATE REC'D BY LOCAL REG. 6/29/49
REGISTRAR'S SIGNATURE A. W. Hedrick
24. FUNERAL DIRECTOR WM. J. TICKNER & SONS ADDRESS Balto., Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

MARYLAND STATE DEPARTMENT OF HEALTH

05389

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No. 20

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY A A — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Edgewater | LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Unknown COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Unknown
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print): (First) VACHEL (Middle) HOYL 83 (Last)

4. DATE OF DEATH: (Month) 6 (Day) 21 (Year) 1949

5. SEX: M | 6. COLOR OR RACE: W | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widower | 8. DATE OF BIRTH: 3/11/1866 | 9. AGE last birthday: 83 yrs. | If under 1 year: Months. Days | If under 24 hrs.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Unknown | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country): A A Co | 12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Vachel | 14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If year, give war or dates of service) | 16. SOCIAL SECURITY NO.: none | 17. INFORMANT: County Home, Edgewater Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Diabetic Gangrene, both feet — 6 mos.

260 Antecedent cause(s)

61 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Diabetic arteriosclerosis. — yrs.

(c) Senility

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan, 1942, to June 21, 1949, that I last saw the deceased alive on June 19, 1949, and that death occurred at 2 4 m., from the causes and on the date stated above.

SIGNATURE (Degree or title) | ADDRESS | DATE SIGNED
Manuel F. Klevans, MD | Annapolis, Md | 6/21/49

23. BURIAL, CREMATION, REMOVAL (Specify): Burial | DATE: 6/22/49 | NAME OF CEMETERY OR CREMATORY: County Home | LOCATION (City, town, or county): Edgewater (State): Md

DATE REC'D BY LOCAL REG.: June 22, 1949 | REGISTRAR'S SIGNATURE: Edward Collens | 24. FUNERAL DIRECTOR: T R Hardesty & Son Galesville Md | ADDRESS

Mrs Collison

I pick this up next time in,

Bernard

RECEIVED
JUN 24 1949
BUREAU V. S.

1949
1866
83

1949
83
1866

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

05390

Evidence for change of age shown on:

FILM NO. G 121 AUG 15 1949

# CERTIFICATE OF DEATH

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK.

VS. A15

1. PLACE OF DEATH: COUNTY A. A. MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Edmore; LENGTH OF STAY (in this place) Life; HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY A. A.; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Edmore; STREET ADDRESS (If rural give location)

3. NAME OF DECEASED (Type or Print): (First) Doris (Middle) Una (Last) Jackson

4. DATE OF DEATH: (Month) June (Day) 11 (Year) 1949

5. SEX: Fem.

6. COLOR OR RACE: Colored

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single

8. DATE OF BIRTH: Dec. 25 1948

9. AGE last birthday: 5 yrs. If under 1 year: Months 5 Days; If under 24 hrs.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none

10b. KIND OF BUSINESS OR INDUSTRY: none

11. BIRTHPLACE (State or foreign country): Washington, D. C.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Shirley Jackson

14. MOTHER'S MAIDEN NAME: Doris Cromwell

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Doris Cromwell

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Pulmonary Tuberculosis

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) (c)

INTERVAL BETWEEN ONSET AND DEATH

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) | PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 3-14, 1949, to 6-12, 1949, that I last saw the deceased alive on 6-11-49, 19....., and that death occurred at 6 A. m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

G. T. Allen M.D. 10 Carroll St. 6-13-49

23. BURIAL, CREMATION REMOVAL (Specify) Burial | DATE June 14 1949 | NAME OF CEMETERY OR CREMATORY Broadneck | LOCATION (City, town, or county) Gt. Margretta (State) Md.

DATE REC'D BY LOCAL REG. June 13, 1949 | REGISTRAR'S SIGNATURE [illegible] D. Smith | 24. FUNERAL DIRECTOR J. B. Johnson | ADDRESS Annapolis

RECEIVED
JUN 14 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

05391

Reg. Dist. No. 29

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH: COUNTY Anne Arundel; STATE MARYLAND; CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville; LENGTH OF STAY (In this place) 27 yrs. 7 mos.; HOSPITAL OR INSTITUTION OR STREET ADDRESS Crownsville State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Dorchester; CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) not known; STREET ADDRESS (If rural, give location) not known

3. NAME OF DECEASED (Type or Print): (First) Tamer; (Middle); (Last) Jackson

4. DATE OF DEATH: (Month) 6/2/49; (Day); (Year) 19

5. SEX: female

6. COLOR OR RACE: colored

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): married

8. DATE OF BIRTH: ~~Unknown~~ ABT. 1867

9. AGE last birthday: 82(?) yrs. If under 1 year: Months; Days; If under 24 hrs.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): unknown

10b. KIND OF BUSINESS OR INDUSTRY: none

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Not known

14. MOTHER'S MAIDEN NAME: Not known

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Hospital Records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Lung Tuberculosis — Interval between onset and death: known since 11/14/47

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b)

(c) Manic Depressive, Psychosis, Manic Type — known since 11/1/21

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 11/1/21, 19....., to 6/2/49, 19....., that I last saw the deceased alive on 6/2/49, 19....., and that death occurred at 6:00 P.M. m., from the causes and on the date stated above.

SIGNATURE Jacob Thompson (Degree or title) M.D. ADDRESS Crownsville, Maryland DATE SIGNED 6/2/49

23. BURIAL, CREMATION REMOVAL (Specify) Burial DATE 6/11/49 NAME OF CEMETERY ~~OR CREMATORY~~ Hospital LOCATION (City, town, or county) (State) Crownsville Md

DATE REC'D BY LOCAL REG. 6/11/49 REGISTRAR'S SIGNATURE E. F. Joyce

24. FUNERAL DIRECTOR Supt. Hospital ADDRESS Crownsville Md

6981
28
1949

RECEIVED
JUN 13 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

05392

# CERTIFICATE OF DEATH

Reg. Dist. No. 2-1

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Anne Arundel; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Parole, near Annapolis; LENGTH OF STAY (in this place) Life; HOSPITAL OR INSTITUTION OR STREET ADDRESS Parole, near Annapolis

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Anne Arundel; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Parole, near Annapolis; STREET ADDRESS (If rural give location) Parole, near Annapolis

3. NAME OF DECEASED (Type or Print): (First) John Agustus (Middle) (Last) Jacobs

4. DATE OF DEATH: (Month) 6/ (Day) 29 (Year) 1949

5. SEX: Male

6. COLOR OR RACE: Colored

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed

8. DATE OF BIRTH: 12/20/ 1869

9. AGE last birthday: 79 yrs. If under 1 year: Months ____ Days ____ If under 24 hrs.: Hours ____ Min. ____

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Cook

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (State or foreign country): Washington , D. C.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Nathaniel A. Jacobs

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service) Navy

16. SOCIAL SECURITY NO.: None

17. INFORMANT: David Jacobs

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Uremia — June 25, 1949

450.0 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

131a (b) Chronic Nephritis; Chronic Prostatitis — May 1947

(c) Arterio Sclerosis

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. None

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Mar, 1947, to June 29, 1949, that I last saw the deceased alive on June 29, 1949, and that death occurred at 7:10 P m., from the causes and on the date stated above.

SIGNATURE R. E. Richardson (Degree or title) M.D. ADDRESS Annapolis, Md. DATE SIGNED 7/1/49

23. BURIAL, CREMATION, REMOVAL (Specify) Burial

DATE THEREOF 7/2/1949

NAME OF CEMETERY OR CREMATORY Brewer Hill Cemetery

LOCATION (City, town, or county) West St. Annapolis, Md (State)

DATE REC'D BY LOCAL REG. July 1, 1949

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR ADDRESS Mrs. Charles E. Hicks & Son- 43-45 Northwest

RECEIVED
JUL 5 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

05393

# CERTIFICATE OF DEATH

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH
COUNTY Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Eastport
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS 821 Bay Ridge Avenue

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE Maryland — COUNTY Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Eastport
STREET ADDRESS (If rural, give location) 821 Bay Ridge Avenue

3. NAME OF DECEASED (Type or Print): (First) Mary (Middle) Elizabeth (Last) Jacobs

4. DATE OF DEATH: (Month) June (Day) 30 (Year) 1949

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed

8. DATE OF BIRTH: 6-15-1877

9. AGE last birthday: 72 yrs. — If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: House

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY: USA

13. FATHER'S NAME: John Drury

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) hypostatic pneumonia — Interval Between Onset and Death: 6 years

Antecedent cause(s)

260

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

61

(b) diabetes, bedsores

(c) one leg amputated 2 yrs ago unable to move blind

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION —

19b. MAJOR FINDINGS OF OPERATION —

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) —

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY — (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July, 19 49, to June 30, 19 49, that I last saw the deceased alive on June 28, 19 49, and that death occurred at 5-53 P m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Edith Radcliffe M.D. 42 State Circle Annapolis July 1st, 1949

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE: July 4, 1949 — NAME OF CEMETERY OR CREMATORY: Cedar Bluff — LOCATION (City, town, or county) (State): Annapolis, Md.

DATE REC'D BY LOCAL REG.: July 2, 1949 — REGISTRAR'S SIGNATURE: [illegible] — M. FUNERAL DIRECTOR: John M. Taylor & Son — ADDRESS: Annapolis, Md.

RECEIVED
JUL 6 1949
BUREAU V. S.

Dr. Richardson

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

05394

EVIDENCE FOR CHANGE OF AGE IS ON:

FILM No. G 12C JUN 17 1949

# CERTIFICATE OF DEATH

Reg. Dist. No. 28

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY: Anne Arundel; STATE: MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Waterbury; LENGTH OF STAY (in this place):

HOSPITAL OR INSTITUTION OR STREET ADDRESS:

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Md.; COUNTY: Anne Arundel; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Waterbury; STREET ADDRESS (If rural give location): Waterbury

3. NAME OF DECEASED (Type or Print): (First) Mary (Middle) C. (Last) Jones

4. DATE OF DEATH: (Month) June (Day) 5 (Year) 1949

5. SEX: Female

6. COLOR OR RACE: Colored

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: April 28, 1898

9. AGE last birthday: 51 yrs. If under 1 year: Months 1, Days 8; If under 24 hrs.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Domestic

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Waterbury, Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Isaac Miller

14. MOTHER'S MAIDEN NAME: Mary Stockett

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service):

16. SOCIAL SECURITY No.:

17. INFORMANT: James H. Jones

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

331 Immediate cause (a) Cerebral Hemorrhage — Interval Between Onset and Death: 3 Days

Antecedent cause(s)

83a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Arterial Hypertension — 3 Months

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. None

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY: (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

INJURY OCCURRED While at Work ☐ Not While at Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June 3, 1949, to June 5, 1949, that I last saw the deceased alive on June 5, 1949, and that death occurred at 2:30 P.M., from the causes and on the date stated above.

SIGNATURE (Degree or title): R. E. Richardson M.D. ADDRESS: 110 - Clay St. Annapolis, Md. DATE SIGNED: June 7, 1949

23. BURIAL, CREMATION REMOVAL (Specify): Burial DATE: June 8, 1949 NAME OF CEMETERY OR CREMATORY: John Wesley LOCATION (City, town, or county) (State): Waterbury, Md

DATE REC'D BY LOCAL REG.: June 8, 1949 REGISTRAR'S SIGNATURE: E. T. Joyce Local Registrar

24. FUNERAL DIRECTOR: J. B. Johnson ADDRESS: Annapolis Md

VS. A15

RECEIVED
JUN 10 1949
BUREAU V. S.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct one is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

05395

# CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH
COUNTY ANNE ARUNDEL
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN GLEN BURNIE
LENGTH OF STAY (in this place) 17 YRS.
HOSPITAL OR INSTITUTION OR STREET ADDRESS 1314 HOWARD ROAD.

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE MARYLAND COUNTY ANNE ARUNDEL
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN HARUNDALE GLEN BURNIE, MD.
STREET ADDRESS (If rural give location) 1314 Howard ROAD.

3. NAME OF DECEASED (Type or Print) (First) JENNY (Middle) E (Last) KELLY.

4. DATE OF DEATH (Month) JUNE (Day) 15 (Year) 1949

5. SEX FEMALE

6. COLOR OR RACE WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) WIDOW

8. DATE OF BIRTH Nov. 24, 1861

9. AGE last birthday 87 yrs. If under 1 year Months — Days — If under 24 hrs. Hours — Min. —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE

10b. KIND OF BUSINESS OR INDUSTRY —

11. BIRTHPLACE (State or foreign country) MARLBORO MASS.

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME GEORGE L. JONES

14. MOTHER'S MAIDEN NAME MARY E. GOODMAN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service) —

16. SOCIAL SECURITY NO. NONE

17. INFORMANT Lewis G. KELLY.

## 18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

442 **Immediate cause** (a) UREMIA

**Antecedent cause(s)** Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

131a (b) CARDIAC DECOMPENSATION

(c) ARTERIOSCLEROTIC CARDIO-VASCULAR RENAL DISEASE

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. NONE

19a. DATE OF OPERATION — 19b. MAJOR FINDINGS OF OPERATION — 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) — PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY — (CITY OR TOWN) — (COUNTY) — (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURRED While at Work ☐ Not While At work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from SEPT., 1948, to JUNE, 1949, that I last saw the deceased alive on JUNE 13, 1949, and that death occurred at 10:00 a.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Henry T. Zangara M.D Glen Burnie June 15, 1949

23. BURIAL, CREMATION, REMOVAL (Specify) Burial — DATE THEREOF June 17, 1949 — NAME OF CEMETERY OR CREMATORY MAPLE WOOD — LOCATION (City, town, or county) (State) MARLBORO, MASS.

DATE REC'D BY LOCAL REG. 6/16/49 — REGISTRAR'S SIGNATURE L. J. Dr Albo — 24. FUNERAL DIRECTOR ADDRESS Thomas W Bengaten, Glen Burnie, Md.

RECEIVED
JUN 17 1949
BUREAU V. S.

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

I

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

05396

# CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Odenton
LENGTH OF STAY (in this place) 13 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS 5th Street

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE MARYLAND COUNTY A. A.
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Odenton
STREET ADDRESS (If rural, give location) Fifth Street.

3. NAME OF DECEASED (Type or Print) (First) Ada. (Middle) E (Last) Klemp
4. DATE OF DEATH (Month) June (Day) 11 (Year) 1949

5. SEX Female
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widow
8. DATE OF BIRTH Jan 8, 1879
9. AGE last birthday 70 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) NEWPORT, R.I
12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME DAVID COOPER
14. MOTHER'S MAIDEN NAME Josephine Perrigo

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If year, give war or dates of service)
16. SOCIAL SECURITY No. None
17. INFORMANT Mrs. Josephine Lamphier

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | Interval Between Onset and Death |
|---|---|---|
| 420.0 Immediate cause | (a) Arterio-sclerotic Heart Disease | 2 years |
| Antecedent cause(s) | | |
| 93d Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (b) | |
| | (c) | |

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Asthma

19a. DATE OF OPERATION —
19b. MAJOR FINDINGS OF OPERATION —
20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct, 1948, to June 11, 1949, that I last saw the deceased alive on June 10, 1949, and that death occurred at 11:40A m., from the causes and on the date stated above.

SIGNATURE Edward G Merritt (Degree or title) M.D. ADDRESS Gambrills Md DATE SIGNED June 13, 49

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE June 14, 1949
NAME OF CEMETERY OR CREMATORY Balto National Cem
LOCATION (City, town, or county) Baltimore (State) MD

DATE REC'D BY LOCAL REG. 6/14
REGISTRAR'S SIGNATURE L. J. D'Alba
24. FUNERAL DIRECTOR Thomas W Sneighton ADDRESS Glen Burnie Md

RECEIVED
JUN 15 1949
BUREAU V. S.

05397

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No. 21

Knickman Dr. Walter E.

1. PLACE OF DEATH: COUNTY Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis — LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Emergency Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. — COUNTY Balto
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore
STREET ADDRESS (If rural, give location) 225 Murdock Rd.

| 3. NAME OF DECEASED (Type or Print) | (First) | (Middle) | (Last) | 4. DATE OF DEATH | (Month) | (Day) | (Year) |
|---|---|---|---|---|---|---|---|
| | Dr. Walter | Edward | Knickman, Sr. | | June | 19, | 1949 |

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH | 9. AGE last birthday | If under 1 year Months | Days | If under 24 hrs. Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| male | white | married | June 2, 1880 | 69 yrs. | | | | |

| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Physician | | Baltimore, Md. | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Henry Edw. Knickman | Emma Wolfe |

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | (If year, give war or dates of service) | 16. SOCIAL SECURITY No. | 17. INFORMANT |
|---|---|---|---|
| yes | World War I & II | | Mrs. Elsie R. Knickman 225 Murdock Rd. |

## 18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| Immediate cause | (a) Coronary Thrombosis | Few hrs. |
| Antecedent cause(s) | | |
| Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (b) | |
| | (c) | |

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| None | None | Yes [ ] No [X] |

| 21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE) |
|---|---|---|---|---|
| None | C | | | |

| TIME OF INJURY (Month) (Day) (Year) (Hour) | INJURY OCCURRED While at Work [ ] Not While At work [ ] | HOW DID INJURY OCCUR? |
|---|---|---|
| None m. | | |

22. I hereby certify that I attended the deceased from 6/3, 1949, to 6/19, 1949, that I last saw the deceased alive on 6/19, 1949, and that death occurred at 10:33 p.m., from the causes and on the date stated above.

SIGNATURE George C. Basil M.D. (Degree or title) ADDRESS DATE SIGNED 6/19/49 F.E.C.

| 23. BURIAL, CREMATION REMOVAL (Specify) | DATE | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | June 23, 1949 | Loudon Park Cem. | Balto., Md. |

| DATE REC'D BY LOCAL REG. | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| 6/21/49 | E. L. Sedrick | WM. J. TICKNER & SONS | Balto., Md. |

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

# CERTIFICATE OF DEATH

## FOR MEDICAL EXAMINERS

Tr. 05398

Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Selby on Bay
LENGTH OF STAY (in this place) 1 day
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY Prince George
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Beltsville.
STREET ADDRESS (If rural, give location) 5 Odell Road

3. NAME OF DECEASED (Type or Print) (First) Garnett (Middle) Arthur (Last) Leitch
4. DATE OF DEATH (Month) June (Day) 27 (Year) 1949

5. SEX male
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single
8. DATE OF BIRTH About 1908
9. AGE last birthday 41 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter
10b. KIND OF BUSINESS OR INDUSTRY Building
11. BIRTHPLACE (State or foreign country) Washington
12. CITIZEN OF WHAT COUNTRY U.S.A

13. FATHER'S NAME Wm. A. Leitch
14. MOTHER'S MAIDEN NAME Myrtle Amelia Pollack

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) World War II
16. SOCIAL SECURITY NO.
17. INFORMANT Edgar M. Yates

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Acute Dilatation of Heart — INTERVAL BETWEEN ONSET AND DEATH: sudden

434.3

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) was in swimming at time of attack

95c

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☑

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at work ☐ Not while at work ☐
HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE Wm. M. Claffy M.D. (Degree or title) Deputy Medical Examiner ADDRESS Annapolis Md DATE SIGNED 6-27-49

23. BURIAL, CREMATION, REMOVAL (Specify) Burial DATE THEREOF June 30/49 NAME OF CEMETERY OR CREMATORY Arlington National LOCATION (City, town, or county) Arlington (State) Va

DATE REC'D BY LOCAL REG. June 29, 1949 REGISTRAR'S SIGNATURE [signature] 24. FUNERAL DIRECTOR W. W. Chambers Co ADDRESS Riverdale, Maryland

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15A

RECEIVED
JUL 5 1949
BUREAU V. S.

Evidence for addition of #18b shown on:

05399

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No. 21

FILM No. G 121 JUL 22 1949

1. PLACE OF DEATH — COUNTY: Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Annapolis — LENGTH OF STAY (in this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 70 Larkin St

2. USUAL RESIDENCE (HOME) OF DECEASED — STATE: Maryland — COUNTY: Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Annapolis
STREET ADDRESS (If rural give location): 70 Larkin St.

3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last): Alice Lewis
4. DATE OF DEATH (Month) (Day) (Year): June 6 1949
5. SEX: Female
6. COLOR OR RACE: Negro
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): married
8. DATE OF BIRTH: 11-1-1901
9. AGE last birthday: 47 yrs. — If under 1 year: Months, Days — If under 24 hrs.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Annapolis
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Rachel Carroll
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service):
16. SOCIAL SECURITY No.:
17. INFORMANT: William Lewis

## 18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Cardiac Failure — 1 day

443 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Hypertensive Cardio Vascular disease (7/31/49-as) — —

93d (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: No
19b. MAJOR FINDINGS OF OPERATION: None
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify): No
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June 6, 1949, to ....., 19....., that I last saw the deceased alive on June 6, 1949, and that death occurred at 4:20P.M. m., from the causes and on the date stated above.

SIGNATURE: Theodore H. Jones M.D. (Degree or title) — ADDRESS: 40 Northwest Street — DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify): Burial — DATE THEREOF: 6-9-1949 — NAME OF CEMETERY OR CREMATORY: Brewer Hill — LOCATION (City, town, or county): Annapolis — (State): Md.

DATE REC'D BY LOCAL REG.: June 9, 1949 — REGISTRAR'S SIGNATURE: [signature] — 24. FUNERAL DIRECTOR: William Reese, II-108 Washington St. Annapolis, Md. — ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
JUN 10 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

# CERTIFICATE OF DEATH

05400

Reg. Diat. No. 21

1. PLACE OF DEATH:
County ANNE ARUNDEL
City or town Pasadena Rural
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life.
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Mayyland County ANNE ARUNDEL
City or town LAKESHORE (PASADENA, P.O. Md)
(If outside city or town limits, write RURAL and give nearest town)
Street No. MOUNTAIN ROAD.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Wesley Linthicum

3.(b) Social Security Number NONE.

4. Sex 87 M | 5. Color or race W | 6.(a) Single, married, widowed, or divorced Widowed

6.(b) Name of husband or wife ANNIE E. LINTHICUM
Nee LANTON 6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 9, 1862

8. AGE: Years 87 | Months | Days | If less than one day ..hrs. ..min.

9. Birthplace ANNE ARUNDEL Co MD.
(Town, county, and state)

10. Usual occupation FARMER (RETIRED)

11. Industry or business OWN FARM.

FATHER
12. Name WESLEY LINTHICUM
13. Birthplace Linthicum Heights, A.A.Co. Md.

MOTHER
14. Maiden name GEORGEANNA Fishack
15. Birthplace Baltimore, Md.

16. Informant HERBERT LINTHICUM.
Address

17. BURIAL (Burial, cremation, or removal. Which?) Date thereof JUNE 29, 1949 (month) (day) (year)
Cemetery or crematory MT. CARMEL Church yd.
Location MOUNTAIN ROAD, A.A.Co. MD.

18. Funeral director Thomas W. Pendleton
Address Glen Burnie Md.

19. 6/28 1949 L. J. Dalba
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH June 26 1949, at 4:30 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1948 to Date 1949
and that I last saw him alive on June 26 1949

| | DURATION |
|---|---|
| Immediate cause of death Myocardial failure. | Immediate |
| Due to Chronic Degenerative Myocarditis; Arterial Hypertension | Unknown |
| Due to Generalized arterio-sclerosis. | Unknown |
| Other conditions Hemiplegia | |

443
93d
(Include pregnancy within 3 months of death)

Major findings of operations None
Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE A. J. Gadaus M.D.
M. D. or other
Address Pasadena, Md Date signed 6/26/49

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-48M

RECEIVED
JUN 29 1949
BUREAU V. M.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

05401

## CERTIFICATE OF DEATH

Reg. Diat. No. 26

**1. PLACE OF DEATH:**

County: Anne Arundel

City or town: Linthicum

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 yrs

Hospital, Institution, or street address where death occurred:

Nursery Rd

How long in hospital or institution?

**2. USUAL RESIDENCE (HOME) OF DECEASED:**

(For newborn infants give residence of mother)

State: Md County: Anne Arundel

City or town: Linthicum

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Nursery Rd

(If rural, give LOCATION)

2.(a) If veteran, name war: none

**3. (a) FULL NAME:** John Mc Donald

**3. (b) Social Security Number:** 705-07-9073

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Male | Col | Married |

6.(b) Name of husband or wife: Louise Mc Donald

6.(c) If alive, give age: 45 years

7. Birth date of deceased (mo., day, yr.): March 23 - 1897

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 52 | | | ...hrs. ...min. |

9. Birthplace: Lincolnton S.C. (Town, county, and state)

10. Usual occupation: Fabr. Mill Claire

11. Industry or business: B&O R.R.

FATHER — 12. Name: Howard Mc Donald

FATHER — 13. Birthplace: S. Carolina

MOTHER — 14. Maiden name: Ella Carter

MOTHER — 15. Birthplace: S. Carolina

16. Informant: Louise Mc Donald

Address: Nursery Rd Linthicum Md

17. (Burial, cremation, or removal. Which?) Burial Date thereof: June 22 49 (month) (day) (year)

Cemetery or crematory: Mt. Auburn

Location: Balto

18. Funeral director: James A Hayes

Address: 742 W Fiel St

19. (Date rec'd by registrar) 6/20 1949 A W Hedrick Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: June 18 1949 at 7.05 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 1948 to June 18 1949

and that I last saw him alive on June 18 1949

| | DURATION |
|---|---|
| Immediate cause of death: Carcinoma of Rectum | 1 yr |
| Due to: Metastasis to liver | 9 mo. |
| Due to: Myocardial disease | 6 hrs. |
| Other conditions: HBP | |

(Include pregnancy within 3 months of death)

Major findings of operations: Carcinoma of Rectum Date of op. Jan 6 '48

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: B B Brumbaugh M. D. or other

Address: Elkridge Md Date signed: 6/18/49

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

05402

# CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY ANNE ARUNDEL MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN ANNAPOLIS
LENGTH OF STAY (in this place) 1 MO
HOSPITAL OR INSTITUTION OR STREET ADDRESS EMERGENCY Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE MARYLAND COUNTY ANNE ARUNDEL
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Witney's LANDING (SEVERNA PARK P.O.
STREET ADDRESS (If rural, give location) None

3. NAME OF DECEASED (Type or Print) (First) Evelyn (Middle) R (Last) MILLER

4. DATE OF DEATH (Month) JUNE (Day) 13 (Year) 1949

5. SEX Female
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married
8. DATE OF BIRTH Apr. 5, 1902
9. AGE last birthday 47 yrs. If under 1 year Months. Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework
10b. KIND OF BUSINESS OR INDUSTRY OWN HOME
11. BIRTHPLACE (State or foreign country) Washington, D.C.
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME James Quigley
14. MOTHER'S MAIDEN NAME Rose Longer

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If year, give war or dates of service)
16. SOCIAL SECURITY NO. NONE
17. INFORMANT Edward F. MILLER

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.1 Immediate cause (a) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH 7 yrs

Antecedent cause(s)

94a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION None
19b. MAJOR FINDINGS OF OPERATION None
20. AUTOPSY? Yes ☑ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 3/25, 1949, to June 13, 1949, that I last saw the deceased alive on June 12, 1949 and that death occurred at 9 A. m., from the causes and on the date stated above.

SIGNATURE Mannie J. Klawans, M.D. (Degree or title) ADDRESS 31 Smithgate Av DATE SIGNED 6/13/49

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE June 16 1949
NAME OF CEMETERY OR CREMATORY GLEN HAVEN
LOCATION (City, town, or county) (State) GLEN BURNIE, Md.

DATE REC'D BY LOCAL REG. 6/16/49
REGISTRAR'S SIGNATURE L. J. De Alba
24. FUNERAL DIRECTOR Thomas W. Singleton ADDRESS Glen Burnie Md

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
JUN 17 1949
BUREAU V. S.

05403

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Crownsville
LENGTH OF STAY (in this place) 21 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS Crownsville State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Baltimore City
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore
STREET ADDRESS (If rural, give location) 1107 Laurens Street

3. NAME OF DECEASED (Type or Print) (First) David (Middle) (Last) Morris
4. DATE OF DEATH (Month) June (Day) 3 (Year) 1949
5. SEX Male
6. COLOR OR RACE colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) married
8. DATE OF BIRTH ~~unknown~~ 1877
9. AGE last birthday 72(?) yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) unknown
10b. KIND OF BUSINESS OR INDUSTRY unknown
11. BIRTHPLACE (State or foreign country) British West Indies
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME Christian Morris
14. MOTHER'S MAIDEN NAME Not known
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If year, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Hospital records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|---|
| 422.1 | Immediate cause | (a) Broncho pneumonia (hypostatic) | 1 day |
| | Antecedent cause(s) | | |
| 93d | Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (b) Chronic myocarditis | unknown |
| | | (c) Generalized Arteriosclerosis | unknown |

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from May 13, 1949, to June 3, 1949, that I last saw the deceased alive on June 3, 1949, and that death occurred at 11:35 P.M., from the causes and on the date stated above.

SIGNATURE Jacob Morgenstern (Degree or title) M.D.
ADDRESS Crownsville, Maryland
DATE SIGNED 6/3/49

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE June 8, 1949
NAME OF CEMETERY OR CREMATORY Laurel
LOCATION (City, town, or county) Baltimore (State) md

DATE REC'D BY LOCAL REG. 6/8/49
REGISTRAR'S SIGNATURE H. W. Hedrick Dm
24. FUNERAL DIRECTOR Mrs Katie R Williams
ADDRESS 322 Schroeder St

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

05404

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Crownsville
LENGTH OF STAY (In this place) 24 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS Crownsville State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Baltimore City
CITY (If outside corporate limits, write RURAL and give nearest towo) OR TOWN B altimore City
STREET ADDRESS (If rurol, give locotion) 1607 Division St.,

3. NAME OF DECEASED (Type or Print) (First) Viva (Middle) (Last) Nelson
4. DATE OF DEATH (Month) 6 (Day) 14 (Year) 19 49
5. SEX Female
6. COLOR OR RACE Colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single
8. DATE OF BIRTH 1897
9. AGE last birthday 52 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) * * * * * * * * *
10b. KIND OF BUSINESS OR INDUSTRY N one
11. BIRTHPLACE (State or foreign country) Georgia
12. CITIZEN OF WHAT COUNTRY? U. S.
13. FATHER'S NAME Thomas C. N elson
14. MOTHER'S MAIDEN NAME Gibbs
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) * * * * (If year, give war or dates of service) * * * *
16. SOCIAL SECURITY NO. * * * * * * *
17. INFORMANT H ospital Records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

296 Immediate cause (a) Coronary occlusion — 2 hours

Antecedent cause(s)

94a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Thrombocytopenic purpura — 8 days

Idiocy — Known since admission 12/4/24

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION * * * * * * *
19b. MAJOR FINDINGS OF OPERATION * * * * * * * * * * * * * * * * * * * * * * * * * *
20. AUTOPSY? Yes ☒ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) * * * * * * *
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) * * * * * * * * m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR? * * * * * * * * * * * * * * * * * * * * * *

22. I hereby certify that I attended the deceased from Oct. 13, 1941, to June 14, 1949, that I last saw the deceased alive on June 14, 1949, and that death occurred at 11:20 A. M., from the causes and on the date stated above.

SIGNATURE Jacob Thorpe Foster M.D. (Degree or title) ADDRESS Crownsville, Maryland DATE SIGNED 6/14/49

23. BURIAL, CREMATION REMOVAL (Specify) buried — DATE 6/17/49 — NAME OF CEMETERY OR CREMATORY Mt. Auburn — LOCATION (City, town, or county) (State) Balto. Md.

DATE REC'D BY LOCAL REG. 6/16/49 — REGISTRAR'S SIGNATURE A. W. Hedrick Jr — 24. FUNERAL DIRECTOR Joseph G. Locks Jr — ADDRESS 1304 N. Central Ave

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

D J Basil

05405

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Emergency Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY A.A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
STREET ADDRESS (If rural give location) Carvel Hall.

3. NAME OF DECEASED (Type or Print) (First) Nettie (Middle) Groves (Last) Newlon
4. DATE OF DEATH (Month) 6 (Day) 10 (Year) 1949
5. SEX Female
6. COLOR OR RACE White
7. ~~SINGLE~~, ~~MARRIED~~, WIDOWED, ~~DIVORCED~~, (Specify)
8. DATE OF BIRTH 12-10-1888
9. AGE last birthday 60 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) —
10b. KIND OF BUSINESS OR INDUSTRY none
11. BIRTHPLACE (State or foreign country) West Virginia
12. CITIZEN OF WHAT COUNTRY? N.S.A.
13. FATHER'S NAME Lemon Groves
14. MOTHER'S MAIDEN NAME Lenora Roomty
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. —
17. INFORMANT Paul J. Newlon

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| Immediate cause | (a) Coronary Thrombosis | 6 hours |
| Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (b) Arteriosclerosis | unknown |
| | (c) Myocarditis Chr. | 3 years |

420.1
93d

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Rheumatoid Arthritis — 10 years

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from ....., 1940, to June 10, 1949, that I last saw the deceased alive on June 10, 1949, and that death occurred at 10.45 A.m., from the causes and on the date stated above.

SIGNATURE George C. Basil (Degree or title) M.D. ADDRESS Annapolis Md DATE SIGNED 6-11-49

23. ~~BURIAL, CREMATION~~ REMOVAL (Specify) DATE THEREOF June 12-49 NAME OF CEMETERY OR CREMATORY LOCATION (City, town, or county) Charleston (State) W. Va.

DATE REC'D BY LOCAL REG. June 12, 1949 REGISTRAR'S SIGNATURE [signature] 24. FUNERAL DIRECTOR John M. Taylor Son ADDRESS Annapolis Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
JUN 14 1949
BUREAU V. S.

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

I

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

05406

# CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY A. A. MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Ferndale
LENGTH OF STAY (in this place) 39
HOSPITAL OR INSTITUTION OR STREET ADDRESS #1. 2nd ave.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md COUNTY A. A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Ferndale
STREET ADDRESS (If rural, give location) 2nd Ave

3. NAME OF DECEASED (Type or Print) (First) Elizabeth (Middle) Stanislawa (Last) Nitka

4. DATE OF DEATH (Month) June (Day) 17 (Year) 1949

5. SEX Female
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married
8. DATE OF BIRTH April 18-1882
9. AGE last birthday 67 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife
10b. KIND OF BUSINESS OR INDUSTRY —
11. BIRTHPLACE (State or foreign country) at sea Ship on high Seas
12. CITIZEN OF WHAT COUNTRY? America

13. FATHER'S NAME Michael Kowalski
14. MOTHER'S MAIDEN NAME Unk.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No
16. SOCIAL SECURITY NO.
17. INFORMANT

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| Immediate cause | (a) Cerebral Haemorrhage | 40 hrs. |
| Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (b) Arterio-sclerosis + Hypertension | 15 yrs. |
| | (c) Cancer of Cervix | 5 yrs. |

331
48a

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Cardio-Vascular Disease 5 yr.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from ....., 1934, to June 17, 1949, that I last saw the deceased alive on 6/17, 1949, and that death occurred at 8:55 P.m., from the causes and on the date stated above.

SIGNATURE Chas. L. Ball Jr (Degree or title) MD ADDRESS Linthicum DATE SIGNED 6/17/49

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE THEREOF 6-21-49
NAME OF CEMETERY OR CREMATORY Holy Rosary
LOCATION (City, town, or county) (State) Balto. County

DATE REC'D BY LOCAL REG. 6/20/49
REGISTRAR'S SIGNATURE A. L. Hedrick Dm.
24. FUNERAL DIRECTOR John M. Webers ADDRESS 401 S. Chester St Balto 31 Md.

507 D. Robinson pt

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

05407

# CERTIFICATE OF DEATH

Reg. Dist. No. 26

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY A.A. MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Friendship; LENGTH OF STAY (In this place); HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE COUNTY; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Friendship; STREET ADDRESS (If rural, give location) A.A. Co. Md.

3. NAME OF DECEASED (Type or Print): (First) Wallace (Middle) Lee (Last) Paddy

4. DATE OF DEATH: (Month) 6 (Day) 30 (Year) 1949

5. SEX: M.

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married

8. DATE OF BIRTH: Oct 28 1868

9. AGE last birthday: 81 yrs. If under 1 year: Months 8 Days | If under 24 hrs.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY: Farmer

11. BIRTHPLACE (State or foreign country): Md.

12. CITIZEN OF WHAT COUNTRY: U.S.A.

13. FATHER'S NAME: John Paddy

14. MOTHER'S MAIDEN NAME: Mary Eyles

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If year, give war or dates of service)

16. SOCIAL SECURITY NO.: —

17. INFORMANT: Mrs Wallace Lee Paddy

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

420.0 **Immediate cause** (a) Arteriosclerotic heart disease

**Antecedent cause(s)**

934 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY | (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 2-10, 1947, to 6-29, 1949, that I last saw the deceased alive on 6-28, 1949, and that death occurred at 7 A. m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

[signature] Huntingtown Md 6/29/49

23. BURIAL, CREMATION REMOVAL (Specify) Burial | DATE 7/2/49 | NAME OF CEMETERY OR CREMATORY Friendship | LOCATION (City, town, or county) (State) Friendship A.A Co.

DATE REC'D BY LOCAL REG. July 1, 1949 | REGISTRAR'S SIGNATURE Grace E. Hutchins Ida Belle Dent - M.D. | 24. FUNERAL DIRECTOR Wm H. Hutchins ADDRESS

RECEIVED
JUL 12 1949
BUREAU T. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

05408

# CERTIFICATE OF DEATH

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis — LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS 22 Madison St.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
STREET ADDRESS (If rural give location) 12 Madison Street

3. NAME OF DECEASED (Type or Print): (First) LOUIS (Middle) HENRY (Last) PEDDICORD

4. DATE OF DEATH: (Month) June (Day) 11, (Year) 1949

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: May 22, 1883

9. AGE last birthday: 66 yrs. — If under 1 year: Months 0 Days 19 — If under 24 hrs.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Painter

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Baltimore Co., Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Micheal T. Peddicord

14. MOTHER'S MAIDEN NAME: Mary A. Stuffer

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no — (If yes, give war or dates of service) no

16. SOCIAL SECURITY NO.: none

17. INFORMANT: Mrs. Sarah E. Peddicord ( Wife )

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

420.0 Immediate cause (a) Arteriosclerotic Heart disease — 2 yrs.

124.b Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Cirrhosis of Liver — ?

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from April 29, 1949 to 6/11, 1949 that I last saw the deceased alive on 6/9, 1949, and that death occurred at 9 A. m., from the causes and on the date stated above.

SIGNATURE (Degree or title) Maurice F. Klemans MD — ADDRESS Annapolis, Md — DATE SIGNED 6/12/49

23. BURIAL, CREMATION REMOVAL (Specify): Burial — DATE THEREOF 6-14-49 — NAME OF CEMETERY OR CREMATORY: Glen Haven Memorial — LOCATION (City, town, or county) (State): Glen Burnie, Maryland

DATE REC'D BY LOCAL REG. June 13, 1949 — REGISTRAR'S SIGNATURE [signature] — 24. FUNERAL DIRECTOR: B.L. Hopping and Son — ADDRESS: Annapolis, Maryland

RECEIVED
JUN 14 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

05409

# CERTIFICATE OF DEATH

Reg. Dist. No. 212

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY A. A. Co. MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Dorsey | LENGTH OF STAY (in this place) 79 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Anne Arundel COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Dorsey Md.
STREET ADDRESS (If rural give location)

3. NAME OF DECEASED (Type or Print): (First) Daniel (Middle) (Last) Reinsnider

4. DATE OF DEATH: (Month) June (Day) 23 (Year) 1949

5. SEX: Male | 6. COLOR OR RACE: White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married | 8. DATE OF BIRTH: Sept. 26. 1869 | 9. AGE last birthday: 79 yrs. | If under 1 year: Months / Days | If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired | 10b. KIND OF BUSINESS OR INDUSTRY: R. R. | 11. BIRTHPLACE (State or foreign country): Md. | 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Valentine Reinsnider | 14. MOTHER'S MAIDEN NAME: Barbara Haug.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No. | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT: Mrs. Basil Reinsnider

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | Interval Between Onset and Death |
|---|---|---|
| 420.1 Immediate cause | (a) Coronary Thrombosis, Ac. | 15 Min. |
| 93d Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (b) Coronary Thrombosis, Chr. | 1 yr. |
| | (c) Myocarditis | 2 yrs. |
| II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. | Arteriosclerosis | ? |

19a. DATE OF OPERATION: None. | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) ✓ | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) ✓ (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan. 1st, 1948 to June 23 1949, that I last saw the deceased alive on June 23 1949, and that death occurred at 10 or P. m., from the causes and on the date stated above.

SIGNATURE (Degree or title) Frank Shipley, M.D. ADDRESS Savage, Md. DATE SIGNED 6/24/49

23. BURIAL CREMATION REMOVAL (Specify) | DATE THEREOF 6/26/49 | NAME OF CEMETERY OR CREMATORY Mt. Zion | LOCATION (City, town, or county) Balto.-Wash. Blvd. (State) Howard Co. Md.

DATE REC'D BY LOCAL REG. June 24/49 | REGISTRAR'S SIGNATURE Clara Kaslight | 24. FUNERAL DIRECTOR Singleton | ADDRESS Glen Burnie

RECEIVED
JUL 6 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

# CERTIFICATE OF STILLBIRTH

Death *

Reg. Dist. No. 21

A certificate must be filed within 24 hours for every stillbirth of 20 weeks' gestation or more (see stub)

1. PLACE OF BIRTH:

County ANNE ARUNDEL

City or town ANNAPOLIS
(If outside city or town limits, write RURAL and give nearest town)

Street address, hospital, or institution:
U.S. NAVAL HOSPITAL ANNAP. MD.

Length of mother's stay in County 18 Months
(How many years, or months, or days. SPECIFY WHICH)

2. USUAL RESIDENCE OF MOTHER:

State MARYLAND

County ANNE ARUNDEL

City or town ANNAPOLIS
(If outside city or town limits, write RURAL and give nearest town)

Street No. 126 PRINCE GEORGE ST.
(If RURAL give LOCATION)

2ND TWIN STILLBORN

THIS CHILD LIVED TEN (10) HOURS AND FORTY TWO (42) MINUTES Died June 19, 1949

3. Name of child Peggy Anne RICKARD #1

4. Date of birth 18 June 1949 Hour 5:08 P M.

5. Sex Female | 6. Twin or triplet Twin

7. No. of weeks pregnancy 24 weeks

FATHER OF CHILD

8. Full name James Edgar RICKARD

9. Color W 10. Age at time of this birth 19 yrs.

11. Usual occupation U.S. Navy

MOTHER OF CHILD

12. Full maiden name Dorothy Jean CLAYE

13. Color W 14. Age at time of this birth 19 yrs.

15. Usual occupation Housewife

16. Other children born to mother (not including present child): (a) How many children of this mother are now living? 0

(b) How many other children were born alive but are now dead? 0 (c) How many other children were *born* dead? 1

17. Did child die before labor? No During labor? No

18. Pregnancy, complications of Multiple pregnancy

19. Labor: (a) Complications of None

(b) Induced? No

20. (a) Was there an operation for delivery? No (Yes or No)

(b) State all operations, if any None

(c) Did child die before operation? NONE

During operation? NONE

21. Cause of stillbirth. Please be specific. For terms like prematurity, asphyxia, etc., try to add cause thereof.

(a) Fetal causes PREMATURITY

776 (b) Maternal causes PLACENTITIS

159

22. I certify to the birth of this child who was born dead* on the date and hour above stated.

Signature [signature] MD
(Specify if M. D., midwife, or other)

Address USNH, ANNAPOLIS, MD.

23. (a) Burial (b) Date thereof 6-20-49
(Burial, cremation or removal) (month) (day) (year)

(c) Cemetery or crematory USN Cemetery Annapolis, Md.

24. (a) Funeral director B.L. HOPPING & Son

(b) Address Annapolis, Md.

25. (a) June 20 1949 (b) [signature]
(Date rec'd by registrar) (Registrar)

26. (To be filled out if no physician was present at delivery.) The above certificate has been examined by me.

Health Officer, per

* See Instruction C on stub.

RECEIVED
JUN 21 1949
BUREAU V. S.

Evidence for change of birth date is on:

FILM No. B 120 JUN -8 1949

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

05411

Reg. Dist. No. 2-1

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Glen Burnie | LENGTH OF STAY (in this place) 10 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS 109 Georgia Ave. NE,

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Glen Burnie.
STREET ADDRESS (If rural give location) 109 Georgia Ave. N. E.

3. NAME OF DECEASED (Type or Print): (First) Henry (Middle) Christian A. (Last) Ritter
4. DATE OF DEATH: (Month) June (Day) 1 (Year) 1949

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed
8. DATE OF BIRTH: Aug. 27, 1846
9. AGE last birthday: 82 yrs. | If under 1 year: Months | Days | If under 24 hrs: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carpenter (Retired)
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Lemgo Germany
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Henry Ritter
14. MOTHER'S MAIDEN NAME: Henrietta Schilling.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT: Chas. Frank Poole.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

331 Immediate cause (a) Cerebral hemorrhage — Interval between onset and death: 2 mo.

83a Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Senility

(c) Arteriosclerosis

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. None

19a. DATE OF OPERATION: None
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify): None
PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from April 2, 1949, to June 1, 1949, that I last saw the deceased alive on June 1, 1949, and that death occurred at 5:15 A m., from the causes and on the date stated above.

SIGNATURE (Degree or title): L. W. Richardson M.D. ADDRESS: DATE SIGNED: June 1, 1949

23. BURIAL, CREMATION, REMOVAL (Specify): Burial
DATE THEREOF: June 1, 1949
NAME OF CEMETERY OR CREMATORY: Cedar Hill
LOCATION (City, town, or county) (State): Brooklyn, Md.

DATE REC'D BY LOCAL REG.: 6/1/49
REGISTRAR'S SIGNATURE: L. J. DeAlba
24. FUNERAL DIRECTOR: Thomas W. Daughtery ADDRESS: Glen Burnie, Md.

RECEIVED
JUN 3 1949
BUREAU U. S.

05412

25

MARYLAND STATE DEPARTMENT OF HEALTH

# CERTIFICATE OF DEATH

## FOR MEDICAL EXAMINERS

Reg. Dist. No. .....

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Brandon Shores Curtis Bay
LENGTH OF STAY (in this place) 18 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS Brandon Shores

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY N. A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Curtis Bay
STREET ADDRESS (If rural, give location) Brandon Shores

3. NAME OF DECEASED (Type or Print) (First) Lillian (Middle) Ruth (Last) Sawyer
4. DATE OF DEATH (Month) June (Day) 24 (Year) 1949
5. SEX Female
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) married
8. DATE OF BIRTH Oct. 13, 1900
9. AGE last birthday 48 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Home
10b. KIND OF BUSINESS OR INDUSTRY Housework
11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME John C. Rice
14. MOTHER'S MAIDEN NAME Annie C. Allen
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) —
16. SOCIAL SECURITY NO. —
17. INFORMANT William D. Sawyer

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|---|
| 443 | Immediate cause | (a) Acute Dilatation of Heart | sudden |
| 48b | Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (b) Chronic myocarditis | unknown |
| | | (c) Arterial hypertension | unknown |

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Carcinoma of Uterus. unknown

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☑

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at work ☐ Not while at work ☐
HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE John A. Caffey M.D. (Degree or title) Deputy Medical Examiner ADDRESS Annapolis, Md. DATE SIGNED 6/24/49

23. BURIAL, CREMATION REMOVAL (Specify) Burial — DATE THEREOF June 27, 1949 NAME OF CEMETERY OR CREMATORY Glen Haven Cemetery LOCATION (City, town, or county) Acacia, Md (State)

DATE REC'D BY LOCAL REG. June 25th 1949 REGISTRAR'S SIGNATURE RWT A W Hedrich
24. FUNERAL DIRECTOR G. Howard Evans ADDRESS 1400 S. Charles St, Baltimore 30, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

05413

# CERTIFICATE OF DEATH

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY Anne Arundel; STATE MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis; LENGTH OF STAY (in this place) 33 yrs.; HOSPITAL OR INSTITUTION OR STREET ADDRESS Emergency Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Anne Arundel; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis; STREET ADDRESS (If rural give location) Hotel Maryland

3. NAME OF DECEASED (Type or Print): (First) FREDERICK (Middle) (None) (Last) SCHOEN

4. DATE OF DEATH: (Month) 6 (Day) 22 (Year) 1949

5. SEX: Male

6. COLOR OR RACE: White

7. ~~SINGLE~~, MARRIED, ~~WIDOWED~~, ~~DIVORCED~~ (Specify): married

8. DATE OF BIRTH: 6-30-1877

9. AGE last birthday: 71 yrs. If under 1 year: Months / Days. If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Real estate business

10b. KIND OF BUSINESS OR INDUSTRY: Real estate

11. BIRTHPLACE (State or foreign country): Germany

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If year, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Mrs. Catherine A. Schoen

## 18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | Interval Between Onset and Death |
|---|---|---|
| Immediate cause | (a) Coronary Thrombosis | 1 hour |
| 420.1 Antecedent cause(s) | | |
| 93 d Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (b) Arteriosclerosis - Cardio-Vascular disease | 3 years |
| | (c) | |

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION (None)

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan. 1, 1949 to June 22, 1949 that I last saw the deceased alive on June 22, 1949 and that death occurred at 11 A.M., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Catherine A. Anderson M.D. Annapolis, Md. June 22, 1949.

23. BURIAL, CREMATION, REMOVAL (Specify): Burial

DATE: 6-25-1949

NAME OF CEMETERY OR CREMATORY: Cedar Bluff

LOCATION (City, town, or county) (State): Annapolis, Md.

DATE REC'D BY LOCAL REG.: June 25, 1949

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR: John M. Taylor & Son

ADDRESS: Annapolis

VS. A15

RECEIVED
JUN 28 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

# CERTIFICATE OF DEATH

## FOR MEDICAL EXAMINERS

05414

Reg. Dist. No. .....

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Point Pleasant, LENGTH OF STAY (in this place) 10 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY A. A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Pt. Pleasant - Brooklyn 25
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) (First) Anna (Middle) R. (Last) SCHROTH
4. DATE OF DEATH (Month) June (Day) 5 (Year) 1949
5. SEX Female
6. COLOR OR RACE White
7. ~~SINGLE~~, MARRIED, ~~WIDOWED~~, ~~DIVORCED~~, (Specify) married
8. DATE OF BIRTH 6/15/96
9. AGE last birthday 52 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10b. KIND OF BUSINESS OR INDUSTRY —
11. BIRTHPLACE (State or foreign country) Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Walter Winks
14. MOTHER'S MAIDEN NAME Margaret Isaac
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No
16. SOCIAL SECURITY NO. —
17. INFORMANT Mr. John Schroth (Husband)

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

420.1 Immediate cause (a) Coronary Occlusion — Sudden

94a Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) General Arthritis — 10 years

(c)

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. —

19a. DATE OF OPERATION —
19b. MAJOR FINDINGS OF OPERATION —
20. AUTOPSY? Yes ☐ No ☑

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at work ☐ Not while at work ☐
HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☑ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE Gustave H. Faulkner M.D. (Degree, or title) Assistant Med. Examiner ADDRESS Glen Burnie, Md. DATE SIGNED 6/5/49

23. BURIAL, CREMATION REMOVAL (Specify) Entombment
DATE THEREOF June 8, 1949
NAME OF CEMETERY OR CREMATORY Lorraine Park Mausoleum
LOCATION (City, town, or county) Balto. Md. (State)
DATE REC'D BY LOCAL REG. 6-7-49
REGISTRAR'S SIGNATURE [illegible]
24. FUNERAL DIRECTOR Howard Evans ADDRESS 1400 S. Charles St. Baltimore 30, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

Evidence for addition of #4 shown on:

FILM NO. G 121 JUL 13 1949

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

05415

# CERTIFICATE OF DEATH

Reg. Dist. No. 20

1. PLACE OF DEATH: COUNTY a a MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Lathiore
LENGTH OF STAY (in this place) 4 months
HOSPITAL OR INSTITUTION OR STREET ADDRESS Hill top Rest Home Lathiore Md

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY a a
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Lathiore
STREET ADDRESS (If rural give location)

3. NAME OF DECEASED (Type or Print) (First) Rachel (Middle) R (Last) Stallings
4. DATE OF DEATH (Month) June (Day) 27 (Year) 1949
5. SEX F
6. COLOR OR RACE W
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) widow
8. DATE OF BIRTH Sept 10-1859
9. AGE last birthday 89 yrs. If under 1 year Months 9 Days 17 If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None
10b. KIND OF BUSINESS OR INDUSTRY None
11. BIRTHPLACE (State or foreign country) Solley Md
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Thomas Solley
14. MOTHER'S MAIDEN NAME Sarah Williams
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No
16. SOCIAL SECURITY NO. No
17. INFORMANT Elmer S Stallings

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| Immediate cause | (a) Cachexia | 2 mos |
| Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (b) Gen arteriosclerosis - severe | Unk |
| | (c) | |

450.0
97

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 26 Jan, 1949, to 27 June, 1949, that I last saw the deceased alive on 26 June, 1949, and that death occurred at 7 40 A m., from the causes and on the date stated above.

SIGNATURE Robert B Tasser (Degree or title) MD ADDRESS Upper Marlboro Md DATE SIGNED 28 June 49

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE THEREOF June 29/49
NAME OF CEMETERY OR CREMATORY Solley's Private
LOCATION (City, town, or county) Solley (State) Maryland
DATE REC'D BY LOCAL REG. 6/28/49
REGISTRAR'S SIGNATURE M R Clayton
24. FUNERAL DIRECTOR B. L. Hopping & Son ADDRESS Annapolis

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
JUL 1 1949
BUREAU V. S.

~~BIRTH AND~~ DEATH Death

MARYLAND STATE DEPARTMENT OF HEALTH

# CERTIFICATE OF ~~STILLBIRTH~~

05416

Reg. Dist. No. 27

A certificate must be filed within 24 hours for every still birth of 20 weeks' gestation or more (see stub)

1. PLACE OF BIRTH:

County ANNE ARUNDEL

City or town
(If outside city or town limits, write RURAL and give nearest town)

Street address, hospital, or institution:
Station Hospital FT G G MEADE, MD

Length of mother's stay in County 1 yr 3mo
(How many years, or months, or days. SPECIFY WHICH)

2. USUAL RESIDENCE OF MOTHER:

State Georgia

County Ware

City or town Ware
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1255 Thomas St
(If RURAL give LOCATION)

3. Name of child TAYLOR (baby boy)

4. Date of birth 18 June 19 49 Hour 0028 hrs. M.

5. Sex Male | 6. Twin or triplet other

7. No. of weeks pregnancy 24

LIVED 1 minute 0028 0029

## FATHER OF CHILD

8. Full name Henry Taylor

9. Color N 10. Age at time of this birth 23 yrs.

11. Usual occupation Soldier

## MOTHER OF CHILD

12. Full maiden name Arilla Williams

13. Color N 14. Age at time of this birth 23 yrs.

15. Usual occupation Housewife

16. Other children born to mother (not including present child): (a) How many children of this mother are now living? 0

(b) How many other children were born alive but are now dead? 0 (c) How many other children were *born* dead?

17. Did child die before labor? No During labor? Yes

18. Pregnancy, complications of Rupture of membranes at 6th month.

19. Labor: (a) Complications of prolapse of umbilical cord. (b) Induced?

20. (a) Was there an operation for delivery? No (Yes or No)

(b) State all operations, if any None

(c) Did child die before operation?

During operation?

21. Cause of stillbirth. Please be specific. For terms like prematurity, asphyxia, etc., try to add cause thereof.

(a) Fetal causes Prematurity, prolapse of cord.

761.5 (b) Maternal causes Premature rupture of

1600 membrane.

22. I certify to the birth of this child who was born dead* on the date and hour above stated.

Signature Dale T. Mills
(Specify if M.D., midwife, or other)

DALE T. MILLS, CAPT., MC

Address FT G G MEADE, MARYLAND

23. (a) Burial (b) Date thereof 20 June 49
(Burial, cremation or removal) (month) (day) (year)

(c) Cemetery or crematory Post cemetery

24. (a) Funeral director Gray Johnson, Lt Chap C

(b) Address FT G G MEADE, MARYLAND

25. (a) 21 June 49 (b) E K Burnside
(Date rec'd by registrar)

E. K. BURNSIDE, CAPT MSC

26. (To be filled out if no physician was present at delivery.) The above certificate has been examined by me.

Health Officer, per

V.S. A10

* See Instruction C on stub.

RECEIVED
JUN 25 1949
BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

05417

# CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH
COUNTY ANNE ARUNDEL MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN North Linthicum
LENGTH OF STAY (In this place) 4 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS FORT MEADE Road

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE MARYLAND COUNTY ANNE ARUNDEL
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN North Linthicum (Linthicum P.O.)
STREET ADDRESS (If rural, give location) FT. MEADE Road

| 3. NAME OF DECEASED (Type or Print) (First) | (Middle) | (Last) | 4. DATE OF DEATH (Month) | (Day) | (Year) |
|---|---|---|---|---|---|
| MARGARET | B | TAYLOR. | JUNE | 13, | 1949 |

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE last birthday | If under 1 year: Months | Days | If under 24 hrs.: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| FEMALE | WHITE | Married | DEC. 18, 1879 | 69 yrs. | — | — | — | — |

| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| NONE | — | BALTIMORE MD | U.S. |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| THOMAS HARFORD | UNKNOWN |

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY No. | 17. INFORMANT |
|---|---|---|
| No | NONE | JOHN T. TAYLOR. |

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

331 **Immediate cause** (a) Cerebral Haemorrhage — 6 hrs

83a **Antecedent cause(s)** Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Arterio-sclerosis — 10 yrs

(c) Arthritis — 14 yrs.

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| — | — | Yes ☐ No ☐ |

| 21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE) |
|---|---|---|---|---|
| — | — | — | — | — |

| TIME OF INJURY (Month) (Day) (Year) (Hour) | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR? |
|---|---|---|
| — m. | — | — |

22. I hereby certify that I attended the deceased from ....., 1935, to June 13, 1949, that I last saw the deceased alive on 6/13, 1949, and that death occurred at 10 P m., from the causes and on the date stated above.

| SIGNATURE | (Degree or title) | ADDRESS | DATE SIGNED |
|---|---|---|---|
| Chas. R. Ball Jr. | MD | Linthicum Md. | 6/13/49 |

| 23. BURIAL, CREMATION REMOVAL (Specify) | DATE THEREOF | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) (State) |
|---|---|---|---|
| BURIAL | JUNE 17 1949 | GLEN HAVEN | GLEN BURNIE MD |

| DATE REC'D BY LOCAL REG. | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| 6/16/49 | [illegible] | Thomas W. Singleton | Glen Burnie Md. |

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. 415

RECEIVED
JUN 20 1949
BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

05418

Reg. Dist. No. 21

**1. PLACE OF DEATH:**

County: Anne Arundel

City or town: Rural - Pasadena

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

**2. USUAL RESIDENCE (HOME) OF DECEASED:**

(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 1100 Hewitt Way

(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

**3.(a) FULL NAME:** Patrick James Terzian (Terzio)

**3.(b) Social Security Number:**

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| M | W | S |

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Dec. 24, 1941

**8. AGE:**

| Years | Months | Days | If less than one day |
|---|---|---|---|
| 7 | 5 | 11 | hrs. min. |

9. Birthplace: Balto. Md.
(Town, county, and state)

10. Usual occupation: Scholar

11. Industry or business: Public School

FATHER

12. Name: Victor P. Terzian

13. Birthplace: Balto Md.

MOTHER

14. Maiden name: Elizabeth Fuget

15. Birthplace: Balto. Md.

16. Informant: Victor P. Terzian

Address: 1100 Hewitt Way

17. Burial (Burial, cremation, or removal. Which?) Date thereof 6/8/49 (month) (day) (year)

Cemetery or crematory: New Cathedral Cemetery

Location: Baltimore, Md.

18. Funeral director: Wm. Cook Inc.

Address: 1212 St. Paul Street

19. June 7 1949 (Date rec'd by registrar) A. W. Hedrick Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: June 5 1949 at 3:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that ~~I attended deceased~~ from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

| Immediate cause of death | DURATION |
|---|---|
| Asphyxiation | |
| Due to: Drowning | |
| Due to: 929.4 | |
| Other conditions: 163 | |

(Include pregnancy within 3 months of death)

Major findings of operation: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident Date of 6/5/49

Where did injury occur? Pasadena (City or town) A.A. (County) Md. (State)

Injured at home, farm, industry, public place (where?): Public beach

Means of injury: Drowning Injured at work? No

23. SIGNATURE: E. Peyton Ritchie, Jr. M.D. (M. D. or other)

Address: Annapolis, Md. Date signed: 6/5/49

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-48 M

MARYLAND STATE DEPARTMENT OF HEALTH TN 115419

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No. 28

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Anne Arundel — MARYLAND
   CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Crownsville
   LENGTH OF STAY (In this place) 10 mos. 19 days
   HOSPITAL OR INSTITUTION OR STREET ADDRESS Crownsville State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Charles C.
   CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Newport
   STREET ADDRESS (If rural, give location) not known

3. NAME OF DECEASED (Type or Print): (First) John (Middle) Grant (Last) Thomas

4. DATE OF DEATH: (Month) 6/5/49 (Day) (Year) 19

5. SEX: male

6. COLOR OR RACE: colored

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) widowed

8. DATE OF BIRTH: ~~1873~~ not known

9. AGE last birthday: 76 yrs.
   If under 1 year: Months / Days
   If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): laborer

10b. KIND OF BUSINESS OR INDUSTRY: none

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: George Thomas

14. MOTHER'S MAIDEN NAME: Julia Edler

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Hospital Records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) General Paresis — Interval between onset and death: known since 7/30/48

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7/16/48, 19....., to 6/5/49, 19....., that I last saw the deceased alive on 6/5/49, 19....., and that death occurred at 6:46 P.M. m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Local Undertaker M.D. Crownsville, Maryland 6/5/49

23. BURIAL, CREMATION REMOVAL (Specify) Burial

DATE 6/8/49

NAME OF CEMETERY OR CREMATORY Crownsville Cemetery

LOCATION (City, town, or county) (State) Crownsville, Maryland

DATE REC'D BY LOCAL REG. 6/8/49

REGISTRAR'S SIGNATURE E. Joyce L Rg.

24. FUNERAL DIRECTOR Supt Hospital ADDRESS Crownsville Md

RECEIVED
JUN 9 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

BC 05420

Reg. Dist. No. 28

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH
COUNTY: Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Crownsville
LENGTH OF STAY (in this place): 2½ weeks
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Crownsville State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland — COUNTY: Baltimore City
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Baltimore
STREET ADDRESS (If rural, give location): 310 N. Mount St.,

3. NAME OF DECEASED (Type or Print): (First) Mary (Middle) Ida (Last) Thomas

4. DATE OF DEATH: (Month) 6 (Day) 20 (Year) 19 49

5. SEX: Female

6. COLOR OR RACE: Colored

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: 12-6-05

9. AGE last birthday: 43 yrs. If under 1 year: Months — Days — If under 24 hrs.: Hours — Min. —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (State or foreign country): North Carolina

12. CITIZEN OF WHAT COUNTRY?: U. S.

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): — (If year, give war or dates of service): —

16. SOCIAL SECURITY NO.: — — — — —

17. INFORMANT: Hospital Records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Carcinoma of the right breast with — Interval between onset and death: Known to us since admission 6/3/49

170 Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) consecutive general carcinosis

50 (c) Organic brain disease

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: — — —

19b. MAJOR FINDINGS OF OPERATION: — — — — — — — — — — — — — — — — — — —

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify): — — — —

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: — — — —

(CITY OR TOWN): — — — — —

(COUNTY): — — —

(STATE): — —

TIME OF INJURY (Month) (Day) (Year) (Hour): — — — — — — m.

INJURY OCCURRED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?: — — — — —

22. I hereby certify that I attended the deceased from June 3, 1949, to June 20, 1949, that I last saw the deceased alive on June 20, 1949, and that death occurred at 3:10 p m., from the causes and on the date stated above.

SIGNATURE (Degree or title): Local Manchester M.D. — ADDRESS: Crownsville, Maryland — DATE SIGNED: 6/20/49

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE: 6/23/49 — NAME OF CEMETERY OR CREMATORY: Mt. Auburn — LOCATION (City, town, or county) (State): Balto. Md.

DATE REC'D BY LOCAL REG.: 6/21/49 — REGISTRAR'S SIGNATURE: E. F. Joyce Local Regr.

24. FUNERAL DIRECTOR: Mrs. S. T. Hensley — ADDRESS: 578 W. Biddle St. Balto. Md.

RECEIVED
JUN 23 1949
BUREAU V. S.

05421

25

MARYLAND STATE DEPARTMENT OF HEALTH

# CERTIFICATE OF DEATH

## FOR MEDICAL EXAMINERS

Reg. Dist. No. .....

1. PLACE OF DEATH — COUNTY: Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Curtis Bay — LENGTH OF STAY (in this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Marley Neck Rd.

2. USUAL RESIDENCE (HOME) OF DECEASED — STATE: Maryland — COUNTY: AA
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Curtis Bay
STREET ADDRESS (If rural, give location): Marley Neck Rd.

3. NAME OF DECEASED (Type or Print): (First) Howard (Middle) (Last) Truitt — Jnr. Mr.
4. DATE OF DEATH: (Month) June (Day) 26 (Year) 1949
5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): widower
8. DATE OF BIRTH: Apr. 3 1875
9. AGE last birthday: 74 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Steel worker
10b. KIND OF BUSINESS OR INDUSTRY: Sup building
11. BIRTHPLACE (State or foreign country): Penn.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: unknown
14. MOTHER'S MAIDEN NAME: Unknown
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): Spanish Am. War
16. SOCIAL SECURITY NO.: 214-18-6293
17. INFORMANT: Clarence R. Truitt.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

260 Immediate cause (a) Acute Dilatation of Heart — sudden

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Chronic Myocarditis — unknown

61 (c) Diabetes Mellitus — unknown

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURRED While at work ☐ Not while at work ☐ — HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE: John M. Caffey M.D. (Degree or title) — ADDRESS: Annapolis Md. Deputy Med. Examiner — DATE SIGNED: 6/27

23. BURIAL, CREMATION REMOVAL (Specify): Burial — DATE THEREOF: 6/26/49 — NAME OF CEMETERY OR CREMATORY: Cedar Hill — LOCATION (City, town, or county): Brooklyn A.A.C. — (State): Md.

DATE REC'D BY LOCAL REG.: 6/28/49 — REGISTRAR'S SIGNATURE: K.W. Heduck DM — 24. FUNERAL DIRECTOR: William Cook Inc — ADDRESS: 1217 H Paul St

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

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# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No. 23

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH
COUNTY: ANNE ARUNDEL — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: GLEN BURNIE
LENGTH OF STAY (in this place): 8 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 313 Central Ave., S.W.

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: MARYLAND — COUNTY: ANNE ARUNDEL
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: GLEN BURNIE, MD
STREET ADDRESS (If rural, give location): 313 CENTRAL AVE. S. W.

| 3. NAME OF DECEASED (Type or Print) (First) | (Middle) | (Last) | 4. DATE OF DEATH (Month) | (Day) | (Year) |
|---|---|---|---|---|---|
| HENRY | WALTER | TUBMAN. | JUNE | 16 | 1949 |

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH | 9. AGE last birthday | If under 1 year: Months | Days | If under 24 hrs.: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| MALE | WHITE | MARRIED | Aug. 21, 1873 | 75 yrs. | — | — | — | — |

| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| CARPENTER (Retired) | B & O. RAILROAD | ST. MARYS, County | U.S. |

13. FATHER'S NAME: SAMUEL TUBMAN

14. MOTHER'S MAIDEN NAME: MARY BEVANS.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): —

16. SOCIAL SECURITY NO.: 705-17-3663

17. INFORMANT: JOSEPH R. TUBMAN

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | Interval Between Onset and Death |
|---|---|---|
| Immediate cause | (a) Cerebral Concussion | 5 days |
| Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (b) Cirrhosis of the Liver | 6 months |
| | (c) | |

900.0
186a

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Cardio-Vascular Disease. — 7 years.

| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| None. | — | Yes ☐ No ☑ |

| 21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE) |
|---|---|---|---|---|
| Fell Down Stairs. | at home. | Glen Burnie. | A.A. Co. | Md. |

| TIME OF INJURY (Month) (Day) (Year) (Hour) | INJURY OCCURRED While at Work ☐ Not While At work ☑ | HOW DID INJURY OCCUR? |
|---|---|---|
| June 11, 1949 8 P.M. | | Fell down Stairs |

22. I hereby certify that I attended the deceased from June 11, 1949, to June 14, 1949, that I last saw the deceased alive on June 14, 1949, and that death occurred at 5:20 m., from the causes and on the date stated above.

| SIGNATURE | (Degree or title) | ADDRESS | DATE SIGNED |
|---|---|---|---|
| James S. Beckingham | M.D. | 108 Central Ave Glen Burnie Md. | June 20, 1949. |

| 23. BURIAL, CREMATION, REMOVAL (Specify) | DATE THEREOF | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | June 20 1949 | GLEN HAVEN | GLEN BURNIE, Md |

| DATE RECD BY LOCAL REG. | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| 6/20/49 | L. J. D'Alba | Thomas W. Singleton | Glen Burnie Md. |

VS. A15

RECEIVED
JUN 21 1949
BUREAU V. S.

05423

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
Annapolis Md
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
LENGTH OF STAY (in this place) 3 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS Emergency Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
STREET ADDRESS (If rural, give location) 10 N. Southwood

3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) Howard W. Tyson

4. DATE OF DEATH (Month) (Day) (Year) 6 25 1949

5. SEX Male
6. COLOR OR RACE White
7. ~~SINGLE~~, MARRIED, ~~WIDOWED~~, ~~DIVORCED~~, (Specify)
8. DATE OF BIRTH May 25 1881
9. AGE last birthday 68 yrs. If under 1 Months. 1 year Days 25 If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Realator
10b. KIND OF BUSINESS OR INDUSTRY Real Estate
11. BIRTHPLACE (State or foreign country) Pennsylvania
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME Sylvester S. Lyson
14. MOTHER'S MAIDEN NAME Ida R. Wersler

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If year, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Robert S. Lyson

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| 422.1 Immediate cause | (a) Cerebral hemorrhage | 6 days |
| Antecedent cause(s) | | |
| 93d Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (b) arteriosclerotic cardio-vascular | |
| | (c) disease | (?) |

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 6/19, 1949, to 6/25, 1949, that I last saw the deceased alive on 6/25, 1949, and that death occurred at 6:15 P m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED
S. Poorsuch M.D 6/25/49

23. BURIAL, CREMATION REMOVAL (Specify) Removal
DATE June 27-49
NAME OF CEMETERY OR CREMATORY
LOCATION (City, town, or county) (State) Phila Pa.

DATE REC'D BY LOCAL REG. June 27, 1949
REGISTRAR'S SIGNATURE [signature]
24. FUNERAL DIRECTOR John B. Taylor & Son
ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
JUN 28 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore

# CERTIFICATE OF DEATH

05424

Reg. Dist. No. 21

**1. PLACE OF DEATH:**
County: Anne Arundel
City or town: Rural - Pasadena
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State: Maryland County: Som
City or town: Crisfield
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Marineri Rd.
(If rural, give LOCATION)
2.(a) If veteran, name war:

**3. (a) FULL NAME:** Louis Emory Watson, Jr.

**3. (b) Social Security Number:**

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| M | W | S |

6.(b) Name of husband or wife: None
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.): Oct. 1, 1930

**8. AGE:**

| Years | Months | Days | If less than one day |
|---|---|---|---|
| 18 | 8 | 4 | ..... hrs. ..... min. |

9. Birthplace: Crisfield, Md (Town, county, and state)
10. Usual occupation: Student
11. Industry or business:
FATHER
12. Name: Louis E. Watson
13. Birthplace: Md
MOTHER
14. Maiden name: Sarah Hedley
15. Birthplace: Balts. Md
16. Informant: Louis E. Watson Sr.
Address: Crisfield, Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof: 6/8/49 (month) (day) (year)
Cemetery or crematory: Sunny Ridge
Location: Crisfield, Md
18. Funeral director: Howard H. Hubbard
Address: 2503 Edmondson Ave, Balts
19. 6/6 1949 (Date rec'd by registrar) [signature] Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: June 5 1949 at 4:30 p.m.
21. I CERTIFY that death occurred on the date above stated; ~~that I attended deceased from~~ ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....
Immediate cause of death: Transection of spinal cord
Due to: fracture of cervical vertebrae
Due to: 857.8
Other conditions: fracture of right femur
(Include pregnancy within 3 months of death) 172
Major findings of operations: ..... Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

DURATION

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accident Date of: 6/5/49
Where did injury occur? Pasadena, G.A., Md. (City or town) (County) (State) (Riviera Beach)
Injured at home, farm, industry, public place (where?): Mayothy River
Means of injury: motorboat struck boat in he was sitting Injured at work?
23. SIGNATURE: E. Peyton Kitchener M.D. acting DME D. or other
Address: Annapolis, Md. Date signed: 6/5/49

VS A15 9-2 M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

05425

# CERTIFICATE OF DEATH

Reg. Dist. No. 21

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN St Margarets; LENGTH OF STAY (In this place); HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY Aa. CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN St Margarets; STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print): (First) Marie (Middle) P. (Last) Wirth

4. DATE OF DEATH: (Month) 6 (Day) 14 (Year) 1949

5. SEX: F.

6. COLOR OR RACE: W.

7. ~~SINGLE~~, MARRIED, WIDOWED, ~~DIVORCED~~. (Specify)

8. DATE OF BIRTH: 12-1-1895

9. AGE last birthday: 53 yrs. If under 1 year: Months. If under 24 hrs.: Days, Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none

10b. KIND OF BUSINESS OR INDUSTRY: none

11. BIRTHPLACE (State or foreign country): St Louis Mo

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Joseph Stauder

14. MOTHER'S MAIDEN NAME: Philamina Roterman

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)

16. SOCIAL SECURITY NO.: –

17. INFORMANT: Mrs Mary M. Goodman St Margarets Aa Co Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

443 Immediate cause (a) Cerebral Hemorrhage — Interval Between Onset and Death: 4 days

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

934 (b) Hypertensive Cardio-Vascular Disease — 10 yrs.

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 6-10-, 1949, to 6-14-, 1949, that I last saw the deceased alive on 6-14-, 1949, and that death occurred at 3 00 p.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

James R. Martin, Md. Annapolis Md. 6-16-49

23. BURIAL, ~~CREMATION~~ REMOVAL (Specify) | DATE | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) (State)

6-17-49 St Mary's Annapolis Md.

DATE REC'D BY LOCAL REG. | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS

June 17, 1949 John M. Taylor Son Annapolis Md.

RECEIVED
JUN 18 1949
BUREAU V. S.

05426

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Winchester
LENGTH OF STAY (in this place) 6 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS Winchester Road

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md COUNTY A.A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Winchester
STREET ADDRESS (If rural give location) Winchester Road

3. NAME OF DECEASED (Type or Print) (First) Elizabeth (Middle) S. (Last) Williams

4. DATE OF DEATH (Month) 6 (Day) 30 (Year) 1949

6. SEX F
6. COLOR OR RACE W
7. ~~SINGLE, MARRIED,~~ WIDOWED, ~~DIVORCED~~, (Specify)
8. DATE OF BIRTH Dec 18th 1862
9. AGE last birthday 86 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) New York State
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Charles Stokes
14. MOTHER'S MAIDEN NAME Jennie V. Barnard

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. —
17. INFORMANT D. Ellwood Williams

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| Immediate cause | (a) Myocarditis Chr. with Myocardial Insufficiency | 2 years |
| Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (b) Arteriosclerosis generalized | Several years. |
| | (c) | |

422.2
93d

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Chr. Rheumatoid Arthritis — 10 years

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Feb, 1946, to June 30, 1949, that I last saw the deceased alive on June 30, 1949, and that death occurred at 4 P.M., from the causes and on the date stated above.

SIGNATURE George C Basil (Degree or title) M.D. ADDRESS Annapolis Md DATE SIGNED June 30th 49

23. BURIAL, ~~CREMATION~~ ~~REMOVAL~~ (Specify)
DATE THEREOF July 2, 1949
NAME OF CEMETERY OR CREMATORY GREEN MOUNT
LOCATION (City, town, or county) (State) BALTIMORE, MD.

DATE REC'D BY LOCAL REG. July 2, 1949
REGISTRAR'S SIGNATURE [signature]
24. ~~FUNERAL~~ DIRECTOR JOHN M. TAYLOR + SON ADDRESS ANNAPOLIS, MD.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
JUL 6 1949
BUREAU V. S.